July 2004

This distribution contains change pages for patch MD*1*2 of the Clinical Procedures 1.0 Technical Manual and Package Security Guide.

Patch MD*1*2 pages:

Replace Pages:	With Pages:
Revision History	Revision History
4.1-4.2	4.1-4.2
10.1-10.30	10.1-10.44

Revision History

Description	Date
Originally released.	April 2004
[1]Patch MD*1*2 released.	July 2004

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[1] Patch MD*1*2 July 2004 Patch 2 release added.

1.   Routine Descriptions

```
²MDAPI      ; HOIFO/DP/NCA - CP API Calls ; [05-05-2003 10:28]
            ;;1.0;CLINICAL PROCEDURES;;Apr 01, 2004
MDAPI1     ; HOIFO/NCA - Electrocardiogram Data Extraction ;12/4/02  12:32
            ;;1.0;CLINICAL PROCEDURES;**1**;Apr 01, 2004
MDHL7A     ; HOIFO/WAA - Routine to Decode HL7 for CP ; [05-07-2001 10:38]
            ;;1.0;CLINICAL PROCEDURES;;Apr 01, 2004
MDHL7B     ; HOIFO/WAA -Bi-directional interface routine ;7/23/01  11:41
            ;;1.0;CLINICAL PROCEDURES;;Apr 01, 2004
MDHL7BH    ; HOIFO/WAA -Bi-directional interface (HL7) routine ;7/23/01  11:41
            ;;1.0;CLINICAL PROCEDURES;;Apr 01, 2004
MDHL7E     ; HOIFO/WAA -Olympus/CMore/Pentax Endoscopy ; 06/08/00
            ;;1.0;CLINICAL PROCEDURES;;Apr 01, 2004
MDHL7K2    ; HOIFO/WAA -HP EnConcert Echo ; 06/08/00
            ;;1.0;CLINICAL PROCEDURES;;Apr 01, 2004
MDHL7M1    ; HOIFO/WAA - Muse EKG ; [02-06-2002 16:13]
            ;;1.0;CLINICAL PROCEDURES;;Apr 01, 2004
MDHL7MCA   ; HIRMFO/REL-Routine to Decode HL7 for MEDICINE ; [05-07-2001 10:38]
            ;;1.0;CLINICAL PROCEDURES;;Apr 01, 2004
MDHL7MCX   ; HIRMFO/WAA - Generate HL7 Error Message for MEDICINE ; [05-07-2001
10:38]
            ;;1.0;CLINICAL PROCEDURES;;Apr 01, 2004
MDHL7P1    ; HOIFO/WAA-Sensormedics,Jaeger Pulmonary ; 06/08/00
            ;;1.0;CLINICAL PROCEDURES;;Apr 01, 2004
MDHL7R1    ; HOIFO/WAA -Clinivision Resporatory ; 06/13/02
            ;;1.0;CLINICAL PROCEDURES;;Apr 01, 2004
MDHL7U     ; HOIFO/WAA -Routine utilities for CP ;7/23/01  11:41
            ;;1.0;CLINICAL PROCEDURES;;Apr 01, 2004
MDHL7U1    ; HOIFO/WAA -Routine utilities for CP PROCESSING OBX ; 7/26/00
            ;;1.0;CLINICAL PROCEDURES;;Apr 01, 2004
MDHL7U2    ; HOIFO/WAA -Utilities for CP PROCESSING OBX text  ; 7/26/00
            ;;1.0;CLINICAL PROCEDURES;;Apr 01, 2004
MDHL7U3    ; HOIFO/WAA -Utilities for CP to process HL7 messages  ; 7/26/00
            ;;1.0;CLINICAL PROCEDURES;;Apr 01, 2004
MDHL7X     ; HOIFO/WAA -Generate HL7 Error Message ; 06/08/00
            ;;1.0;CLINICAL PROCEDURES;;Apr 01, 2004
MDHL7XXX   ; HOIFO/DP - Loopback device for CP ; 22-MAY-2003 13:37:41
            ;;1.0;CLINICAL PROCEDURES;;Apr 01, 2004
MDPCE      ; HIRMFO/NCA - Routine For Data Extract ; [05-28-2002 12:55]
            ;;1.0;CLINICAL PROCEDURES;;Apr 01, 2004
MDPFTP1    ;HOIFO/NCA - PFT REPORT-DEMO INFO ;3/15/04  11:55
            ;;1.0;CLINICAL PROCEDURES;**2**;Apr 01, 2004
MDPFTP2    ; HOIFO/NCA - PFT REPORT-VOLUMES ;3/15/04  10:00
            ;;1.0;CLINICAL PROCEDURES;**2**;Apr 01, 2004
MDPFTP2A   ; HOIFO/NCA - PFT REPORT-FLOWS ;3/17/04  08:22
            ;;1.0;CLINICAL PROCEDURES;**2**;Apr 01, 2004
MDPFTP3    ; HOIFO/NCA - PFT REPORT-SPECIAL STUDIES (PT 2) ;3/17/04  12:48
            ;;1.0;CLINICAL PROCEDURES;**2**;Apr 01, 2004
MDPOST     ; HOIFO/DP - Post Init ;2/18/04  11:39
            ;;1.0;CLINICAL PROCEDURES;;Apr 01, 2004
MDPOST1    ; HOIFO/NCA/DP - Build CP DEFINITION file (#702.01) - Optional Post
Init ; [12-04-2002 13:06]
            ;;1.0;CLINICAL PROCEDURES;;Apr 01, 2004
MDPS1      ; HOIFO/NCA - CP/Medicine Report Generator ;5/18/04  09:48
            ;;1.0;CLINICAL PROCEDURES;**2**;Apr 01, 2004
```

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[2] Patch MD*1*2 July 2004 New routine listing, several routines added.

```
MDPS2       ; HOIFO/NCA - CP/Medicine Report Generator (Cont.) ;5/18/04   09:41
            ;;1.0;CLINICAL PROCEDURES;**2**;Apr 01, 2004
MDPS3       ; HOIFO/NCA - Remote Data View Data Retriever for CP ;4/29/04  10:50
            ;;1.0;CLINICAL PROCEDURES;**2**;Apr 01, 2004
MDRPCOD     ; HOIFO/DP - Object RPCs (TMDProcedureDef) ; [01-09-2003 15:20]
            ;;1.0;CLINICAL PROCEDURES;;Apr 01, 2004
MDRPCOG     ; HOIFO/DP - CP Gateway ; [01-09-2003 15:20]
            ;;1.0;CLINICAL PROCEDURES;;Apr 01, 2004
MDRPCOL     ; HOIFO/DP - Object RPCs (Logfile) ; [02-11-2002 13:41]
            ;;1.0;CLINICAL PROCEDURES;;Apr 01, 2004
MDRPCOO     ; HOIFO/DP - Object RPCs (TMDOutput) ; [03-24-2003 15:44]
            ;;1.0;CLINICAL PROCEDURES;;Apr 01, 2004
MDRPCOP     ; HOIFO/DP - Object RPCs (TMDPatient) ; [01-09-2003 15:21]
            ;;1.0;CLINICAL PROCEDURES;;Apr 01, 2004
MDRPCOR     ; HOIFO/DP - Object RPCs (TMDRecordId) ; [01-10-2003 09:14]
            ;;1.0;CLINICAL PROCEDURES;;Apr 01, 2004
MDRPCOT     ; HOIFO/DP/NCA - Object RPCs (TMDTransaction) ;12/5/02  15:33
            ;;1.0;CLINICAL PROCEDURES;;Apr 01, 2004
MDRPCOT1  ; HOIFO/NCA/DP - Object RPCs (TMDTransaction) - Continued ; [08-02-
2002 12:55]
            ;;1.0;CLINICAL PROCEDURES;;Apr 01, 2004
MDRPCOU     ; HOIFO/DP - Object RPCs (TMDUser) ; [01-09-2003 15:21]
            ;;1.0;CLINICAL PROCEDURES;;Apr 01, 2004
MDRPCOV     ; HOIFO/DP - Object RPCs (TMDParameter) ; [04-15-2003 12:42]
            ;;1.0;CLINICAL PROCEDURES;;Apr 01, 2004
MDRPCU      ; HOIFO/DP - Object RPC Utilities ; [05-23-2003 10:16]
            ;;1.0;CLINICAL PROCEDURES;;Apr 01, 2004
```

10. External Relations

1. The following describes the installation environment for Version 1.0 of the Clinical Procedures package on the VistA server:
   1. VA FileMan V. 22 or greater
   2. Kernel V. 8.0 or greater
   3. Kernel Toolkit V. 7.3 or greater
   4. Kernel RPC Broker V. 1.1 or greater
   5. PIMS (Patient Information Management System) V. 5.3 or greater (including):
      a. Registration V. 5.3
      b. Scheduling V. 5.3
   6. Health Summary V. 2.7 or greater
   7. HL7 (Health Level 7) V. 1.6 or greater
   8. Consults/Request Tracking V. 3.0
   9. TIU (Text Integration Utility) V. 1.0
   10. Order Entry V. 3.0 (CPRS (Computerized Patient Record System) V. 1.0 (GUI V. 18.8)) or greater
   11. PCE (Patient Care Encounter) V. 1.0 or greater
   12. VistA Imaging V. 3.0 or greater (includes installation of background processor and jukebox)
   13. Medicine V. 2.3 (optional)

   These packages must be patched up through and including the following patches before Clinical Procedures is installed:
   1. Patch 17 of Consults/Request Tracking V. 3.0 (GMRC*3.0*17)
   2. Patch 112 of Order Entry V. 3.0 (OR*3.0*112)
   3. Patch 109 of Text Integration Utility V. 1.0 (TIU*1.0*109)
   4. Patch 7 of Imaging V. 3.0 (MAG*3.0*7)
   5. Patch 93 of HL7 V. 1.6 (HL*1.6*93)
   6. Patch 98 of HL7 V. 1.6 (HL*1.6*98)
   7. If Medicine V. 2.3 is installed, you must install Patch 24 of Medicine (MC*2.3*24), and Patch 146 of Kernel (XU*8.0*146).

2. Existing integration agreements between the Clinical Procedures software and other VistA applications are summarized below.

DBIA's where the Clinical Procedures package is the subscriber:

```
     1096      NAME: PATIENT MOVEMENT file cross reference
  CUSTODIAL PACKAGE: REGISTRATION                                 Albany
SUBSCRIBING PACKAGE: AUTOMATED MED INFO EXCHANGE                  Albany
                     CLINICAL PROCEDURES
                     ORDER ENTRY/RESULTS REPORTING
                     CLINICAL REMINDERS
               USAGE: Controlled Subscri   ENTERED: JAN  3,1995
```

```
                STATUS: Active              EXPIRES:
              DURATION: Till Otherwise Agr  VERSION:
                  FILE: 405                    ROOT: DGPM(
           DESCRIPTION:                        TYPE: File
  Patient Movement file (#405)
   - The "ATID1" xref.of the Patient Movement file.  This is to order
  through admissions in inverse date order.
  GLOBAL REFERENCE:
    ^DGPM(
     The "ATID1" xref.of the Patient Movement file.  This is to order
     through admissions in inverse date order.
          KEYWORDS:
```

```
                     *************************


      1496      NAME: DBIA1495-B
   CUSTODIAL PACKAGE: HEALTH LEVEL SEVEN     HL               San Francisco
 SUBSCRIBING PACKAGE: CONTROLLED SUBSTANCES                   Birmingham
                      LAB SERVICE                             Dallas
                      SURGERY                                 Birmingham
                      SCHEDULING                              Albany
                      OUTPATIENT PHARMACY                     Birmingham
                         Only uses Read w/Fileman on the .01 field.
                      KERNEL
                      CLINICAL PROCEDURES
                 USAGE: Controlled Subscri  ENTERED: FEB 22,1996
                STATUS: Active              EXPIRES:
              DURATION: Till Otherwise Agr  VERSION:
                  FILE: 870                    ROOT: HLCS(870,
           DESCRIPTION:                        TYPE: File
  Write access permitted to the HL LOGICAL LINK file to allow installation
  to populate necessary fields to support interfaces.
  GLOBAL REFERENCE:
   ^HLCS(870,
    .01      NODE                 0;1     Write w/Fileman
     2       LLP TYPE             0;3     Write w/Fileman
          KEYWORDS:
```

```
                     *************************


      1889      NAME: DBIA1889-A
   CUSTODIAL PACKAGE: PCE PATIENT CARE ENCOUNTER                Albany
 SUBSCRIBING PACKAGE: CLINICAL PROCEDURES
                 USAGE: Controlled Subscri  ENTERED: JAN 23,1997
                STATUS: Active              EXPIRES:
              DURATION: Next Version        VERSION: 1.0
                  FILE:                        ROOT:
           DESCRIPTION:                        TYPE: Routine
   PURPOSE:  Provide a utility for ancillary packages such as Laboratory,
             Surgery, Medicine, Radiology, Text Integration Utility (TIU)
             and Computerized Patient Record System (CPRS) to non-
             interactively (silently) add/edit/delete data, including
             encounter,  provider, diagnosis and procedure information.

   Dr. Kizer's 10/1/96 mandate which requires a provider, a procedure and a
   diagnosis to positively document the occurrence of an encounter, and the
   resulting change to use this data rather than stop codes to document
   workload and initiate third party billing,  necessitated the development
```

of an application programmer interface (API) which would support the mandated requirements. PCE was tasked with developing the API. $$DATA2PCE^PXAPI was developed to enable the adding, editing and deletion of encounter, provider, diagnosis and procedure data. Data will be stored in the Visit and V files and will be posted on the PXK VISIT DATA EVENT for use by subscribing packages such as Scheduling.

This document includes:
  1. Definitions and Conventions used to describe the API.
  2. Description of $$DATA2PCE^PXAPI, its parameter definitions, and the returned values.
  3. A table which describes the subscripts used for passing data to PCE.
  4. An example array for passing data to PCE.

DEFINITIONS AND CONVENTIONS:

Listed below are definitions and conventions used to describe this API.

  1. Valid data values: [1 | 0 | null]
     `1' Denotes TRUE or YES
     `0' Denotes FALSE or NO
     null Denotes VALUE NOT KNOWN
  2. Counter "i" is used as a subscript. It denotes a sequence number, i.e., 1, 2,
  3. To denote deletion of a data ITEM, pass the "@" symbol as the data value in the node for the item being deleted. You may not delete required data items.
  4. To denote deletion of an ENTRY, pass "1" as the data value in the "DELETE" node of the identified entry.

$$DATA2PCE^PXAPI(INPUT_ROOT,PKG,SOURCE,.VISIT,USER,ERR_DISPLAY))

This is a function which will return a value identifying the status of the call. Data that is processed by PCE will be posted on the PXK VISIT DATA EVENT protocol.

Parameter Description:

  1. INPUT_ROOT: (required) Where INPUT_ROOT is a unique variable name, either local array or global array, which identifies the defined data elements for the encounter. An example of an INPUT_ROOT is ^TMP("LRPXAPI",$J) or ^TMP("RAPXAPI",$J). The gross structure of the array includes four additional subscripts (ENCOUNTER, PROVIDER, DX/PL, PROCEDURE and STOP) for defining the data passed. A detailed description of this array and its structure are included below in a table format.

  2. PKG: (required) Where PKG is a pointer to the Package File (9.4).

  3. SOURCE: (required) Where SOURCE is a string of text (3-30 character) identifying the source of the data. The text is the SOURCE NAME field (.01) of the PCE Data Source file (839.7). If the SOURCE currently does not exist in the file, it will be added. Examples of SOURCE are: "LAB DATA" or "RADIOLOGY DATA" or "PXCE DATA ENTRY" or "AICS ENCOUNTER FORM."

4. VISIT: (optional) Where VISIT is a pointer to the Visit
   file (9000010) which identifies the encounter which this data
   should be associated with.
   If the pointer to the Visit file is saved, it is necessary to
   also subscribe to IA 1902.

5. USER: (optional) User who is responsible for add/edit/delete
   action on the encounter. Pointer to the New Person file (200).
   If USER is not defined, DUZ will be used.

6. ERR_DISPLAY: (optional) To display errors during development,
   this variable may be set to "1". If it is defined the errors will
   be displayed on screen when the error occurs. If ERR_DISPLAY is
   not defined, errors will be posted on the defined INPUT_ROOT
   subscripted by "DIERR". BLD^DIALOG is used to manage errors.
   Review BLD^DIALOG and MSG^DIALOG descriptions included in the
   FileMan v. 21.0 Programmer Manual on pages 189 - 200.

Returned Value:

 1   If no errors occurred and data was processed.
-1   An error occurred. Data may or may not have been processed.
     If ERR_DISPLAY is undefined, errors will be posted on the
     INPUT_ROOT subscripted by "DIERR".
-2   Unable to identify a valid VISIT. No data was processed.
-3   API was called incorrectly. No data was processed.

ENCOUNTER: All data must be associated with an entry in the VISIT file
(#9000010). Only one "ENCOUNTER" node may be passed with each call to
$$DATA2PCE^PXAPI. The "ENCOUNTER" node documents encounter specific
information and must be passed:
   1.   To create an entry in the VISIT file (9000010). All provider,
        diagnosis and procedure data is related to an entry in the
        VISIT file.
   2.   To enable adding, editing or deleting "ENCOUNTER" node data
        elements. When encounter data elements are not added, edited or
deleted, the VISIT parameter may be passed in lieu of defining an
"ENCOUNTER" node.

SUBSCRIPT DESCRIPTION:

 "ENCOUNTER",1,"ENC D/T")   Required
     This is the encounter date/ time for primary encounters or the date
          for occasions of service. If the encounter is related to an
          appointment, this is the appointment date/time. If this is an
          occasion of service created by an ancillary package, this is
          the date/time of the instance of care.
          Imprecise dates are allowed for historical encounters.
          Encounter date/time may be added, but not edited.
         *Deletions of encounters can occur only when nothing is pointing
          to the encounter.
     Format: FileMan Internal Format for date/time
 "ENCOUNTER",1,"PATIENT")   Required
     This is the patient DFN. This cannot be edited or deleted.
     Format: Pointer to IHS Patient file (9000001)
          This file is Dinumed to the Patient file (2)

```
"ENCOUNTER",1,"HOS LOC")                              Required
    This is the hospital location where the encounter took place for
        primary encounters, or this is the ordering location for
        ancillary encounters.
    Format:  Pointer to Hospital Location file (44)
"ENCOUNTER",1,"OUTSIDE LOCATION")                     Optional
    This is an outside location of an encounter, not included in the
        INSTITUTION file.
    Format: Free text (2-245 characters)
    The OUTSIDE LOCATION should exclude the INSTITUTION:
     "ENCOUNTER:,1,"INSTITUTION") and the INSTITUTION should exclude
      the OUTSIDE LOCATION.
"ENCOUNTER",1,"INSTITUTION")                          Optional
    This is the Institution where the encounter took place.  If it is
        not defined, the division defined for the Hospital Location is
        used.  If that is not defined, $$SITE^VASITE is used.
    Format:  Pointer to IHS Location file (9999999.06).
        This file is dinumed to the Institution file (4).
"ENCOUNTER",1,"SC")                                   Optional
    This encounter is related to a service connected condition.
    Format:  [ 1 | 0 | null ]
"ENCOUNTER",1,"AO")                                   Optional
    This encounter is related to Agent Orange exposure.
    Format:  [ 1 | 0 | null ]
"ENCOUNTER",1,"IR")                                   Optional
    This encounter is related to Ionizing Radiation exposure.
    Format:  [ 1 | 0 | null ]
"ENCOUNTER",1,"EC")                                   Optional
    This encounter is related to Environmental Contaminant exposure.
    Format:  [ 1 | 0 | null ]
"ENCOUNTER",1,"MST")                                  Optional
    This encounter is related to Military Sexual Trauma.
    Format:  [ 1 | 0 | null ]
"ENCOUNTER",1,"HNC")                                  Optional
    This encounter is related to Head & Neck Cancer.
    Format:  [ 1 | 0 | null ]
"ENCOUNTER",1,"CHECKOUT D/T")                         Optional
    This is the date/time when the encounter was checked out.
    Format:  FileMan Internal Format for date/time
"ENCOUNTER",1,"ELIGIBILITY")                          Optional
    This is the eligibility of the patient for this encounter.
    Format:  Pointer to Eligibility Code file (8)
"ENCOUNTER",1,"APPT")                                 Optional
    This is the appointment type of the encounter.
    Format:  Pointer to Appointment Type file (409.1)
"ENCOUNTER",1,"SERVICE CATEGORY")                     Required
    This denotes the type of encounter.
    Format:  Set of Codes.
        A::=Ambulatory
            Should be used for clinic encounters.  "A" s are changed
            to "I"s by Visit Tracking if patient is an inpatient at
            the time of the encounter.
        H::=Hospitalization
            Should be used for an admission.
        T::=Telecommunications
        E::=Event (Historical)
            Documents encounters that occur outside of this facility.
            Not used for workload credit or 3rd party billing.
```

```
             X::=Ancillary  Package Daily Data.
                  "X" s are changed to "D"s by Visit Tracking if patient is
                  an inpatient at the time of the encounter.
   "ENCOUNTER",1,"ENCOUNTER TYPE")                              Required
        This identifies the type of  encounter, e.g.,  primary encounter,
             ancillary encounter, etc.  A "Primary" designation indicates
             that the encounter is associated with an appointment or is a
             standalone. Examples of ancillary encounters include
             Laboratory and Radiology instances of care.
        Format:  Set of Codes.
             P::=Primary
             O::=Occasion of Service
             A::=Ancillary
   "ENCOUNTER",1,"PARENT")                                     Optional
        This is the parent encounter for which the ENCOUNTER is a
             supporting encounter.  For example, this would be the primary
             encounter for which this occasion of service supports and
             should be associated.
        Format:  Pointer to Visit file (9000010).
   "ENCOUNTER",1,"COMMENT")                                    Optional
        Comment
        Format:  Free Text  (1-245 characters)
```

PROVIDER: The "PROVIDER" node may have multiple entries (i) and documents
the provider, indicates whether he/she is the primary provider, and
indicates whether the provider is the attending provider. Comments may
also be passed. To delete the entire "PROVIDER" entry, set the "DELETE"
node to 1.

SUBSCRIPT DESCRIPTION:

```
 "PROVIDER",i,"NAME")                                         Required
      Provider's IEN.
      Format:  Pointer to NEW PERSON file (200)
 "PROVIDER",i,"PRIMARY")                                      Optional
      Indicator that denotes this provider as the "primary" provider.
      Format:  [ 1 | 0 | null ]
 "PROVIDER",i,"ATTENDING")                                    Optional
      Indicator that denotes this provider as the attending provider.
      Format:  [ 1 | 0 | null ]
 "PROVIDER",i,"COMMENT")                                      Optional
      Comment
      Format:  Free text (1 - 245 characters)
 "PROVIDER",i,"DELETE")                                       Optional
      This is a flag that denotes deletion of the Provider entry.
      Format:  [ 1 | null ]|
```

DX/PL: The "DX/PL" node may have multiple entries (i) and documents
diagnoses and/or problems. Only active ICD-9-CM codes will be accepted.
The "DX/PL" node adds diagnoses to the PCE database as well as adding an
active or inactive diagnosis or problem to the Problem List. If a
diagnosis or problem already exists on the Problem List, this node may be
used to inactivate it. To delete the entire "DX/PL" entry from PCE (not
Problem List), set the "DELETE" node to 1.

```
SUBSCRIPT DESCRIPTION:


 "DX/PL",i,"DIAGNOSIS")           Required for PCE     Optional for PL
     Diagnosis code
     Format:  Pointer to ICD9 Diagnosis file (80)
 "DX/PL",i,"PRIMARY")             Optional for PCE     N/A for PL
     Code that specifies that the diagnosis is the "primary" diagnosis
         for this encounter.  Only one "primary" diagnosis is recorded
         for each encounter.
     Format:  [ 1 | 0 | null ]
 "DX/PL",i,"LEXICON TERM")        Optional for PCE     Optional for PL
     This is a term that is contained in the Clinical Lexicon.
     Format:  Pointer to the Expressions file (757.01)
 "DX/PL",i,"PL IEN")              Optional for PCE     *Optional for PL
     This is the problem IEN that is being acted upon.  *This node is
         required to edit an existing problem on the Problem List.
     Format:  Pointer to Problem List file (9000011)
 "DX/PL",i,"PL ADD")              N/A for PCE          *Optional for PL
     *This is required to Add a diagnosis/problem to the Problem List.
         "1" indicates that the entry should be added to the Problem
         List.
     Format:  [ 1 | 0 | null ]
 "DX/PL",i,"PL ACTIVE")           N/A for PCE          Optional for PL
     This documents whether a problem is active or inactive.  The
         Default is Active if not specified.
     Format:  Set of Codes.
         A::=Active
         I::=Inactive
 "DX/PL",i,"PL ONSET DATE")       N/A for PCE          Optional for PL
     The date that the problem began.
     Format:  FileMan Internal Format for date.
 "DX/PL",i,"PL RESOLVED DATE")    N/A for PCE          Optional for PL
     The date that the problem was resolved.
     Format:  FileMan Internal Format for date.
 "DX/PL",i,"PL SC")               N/A for PCE          Optional for PL
     This problem is related to a service connected condition.
     Format:  [ 1 | 0 | null ]
 "DX/PL",i,'PL AO")               N/A for PCE          Optional for PL
     This problem is related to Agent Orange exposure.
     Format:  [ 1 | 0 | null ]
 "DX/PL",i,"PL IR")               N/A for PCE          Optional for PL
     This problem is related to Ionizing Radiation exposure.
     Format:  [ 1 | 0 | null ]
 "DX/PL",i,"PL EC")               N/A for PCE          Optional for PL
     This problem is related to Environmental Contaminant exposure.
     Format:  [ 1 | 0 | null ]
 "DX/PL",i,"NARRATIVE")           *Optional for PCE    *Optional for PL
     The provider's description of the diagnosis/problem.  *If NARRATIVE
         is not passed for a diagnosis/problem, the Description  from
         the ICD Diagnosis file (80) will be used as the default.
     Format:  Free text (2-245 characters)
 "DX/PL",i,"CATEGORY")            Optional for PCE     N/A for PL
     A term that denotes a grouping or category for a set of related
         diagnosis/problem.
     Format:  Free text (2-245 characters)
```

```
   "DX/PL",i,"ENC PROVIDER")          Optional for PCE      *Optional for PL
        Provider who documented the diagnosis/problem.
        *This is required to Add a diagnosis/problem to the Problem List.
        Format:  Pointer to New Person file (200)
   "DX/PL",i,"EVENT D/T")             Optional for PCE      N/A for PL
        Date/Time Diagnosis was documented.
        Format:  FileMan Internal Format for date/time
   "DX/PL",i,"COMMENT")               Optional for PCE      *Optional for PL
        Comment
        Format:  PCE Free Text  (1-245 char)
                 PL  Free Text (3-60 char)
   "DX/PL",i,"DELETE")                Optional for PCE      N/A for PL
        This is a delete flag used to denote deletion of the diagnosis
             entry.
        Format:  [ 1 | null ]|
```

PROCEDURE: The "PROCEDURE" node may have multiple entries (i). Only active CPT/HCPCS codes will be accepted. The "PROCEDURE" node documents the procedure(s), the number of times the procedure was performed, the diagnosis the procedure is associated with and the narrative that describes the procedure. It also enables documentation of the provider who performed the procedure, the date/time the procedure was performed and any comments that are associated with the procedure. To delete the entire "PROCEDURE" entry, set the "DELETE" node to 1.

SUBSCRIPT DESCRIPTION:

```
 "PROCEDURE",i,"PROCEDURE")                               Required
        Procedure code
        Format:  Pointer to CPT file (81)
 "PROCEDURE",i,"MODIFIERS",MODIFIER)=""                   Optional
        CPT Modifier(s)
        Format:  external form.  Any number of modifiers may be listed.
 "PROCEDURE",i,"QTY")                                     Required
        Number of times the procedure was performed.
        Format:  Whole number > 0
 "PROCEDURE",i,"DIAGNOSIS")                               Optional
        The diagnosis that is associated with the identified procedure.
        Format:  Pointer to ICD Diagnosis file (80)
 "PROCEDURE",i,"NARRATIVE")                               *Optional
        The provider's description of the procedure performed. *If
            NARRATIVE is not passed for a procedure, the Short Name  from
            the CPT file (81) will be used as the default.
        Format:  Free text (2-245 characters)
 "PROCEDURE",i,"CATEGORY")                                Optional
        A term that denotes a grouping or category for a set of related
            procedures.
        Format:  Free text (2-245 characters)
 "PROCEDURE",i,"ENC PROVIDER")                            Optional
        Provider who performed the procedure.
        Format:  Pointer to New Person file (200)
 "PROCEDURE",i,"EVENT D/T")                               Optional
        Date/Time procedure was done.
        Format:  FileMan Internal Format for date/time
 "PROCEDURE",i,"COMMENT")                                 Optional
        Comment
        Free Text  (1-245 characters)
```

```
    "PROCEDURE",i,"DELETE")                                        Optional
        This is a flag that denotes deletion of the Procedure entry.
        Format:  [ 1 | null ]|
```

```
PATIENT ED:   The "PATIENT ED" node may have multiple entries (i). To
delete the entire "PATIENT ED" entry, set the "DELETE" node to 1.

SUBSCRIPT DESCRIPTION:

 "PATIENT ED",i,"TOPIC")                                         Required
        Education Topic that patient received education.
        Format:  Pointer to Education Topics file (9999999.09)
 "PATIENT ED",i,"UNDERSTANDING")                                 Optional
        The patients level of understanding of the education.
        Format:  Set of Codes.
             1::=Poor
             2::=Fair
             3::=Good
             4::=Group--No Assessment
             5::=Refused
 "PATIENT ED",i,"ENC PROVIDER")                                  Optional
        Provider who was the educator.
        Format:  Pointer to New Person file (200)
 "PATIENT ED",i,"EVENT D/T")                                     Optional
        Date/Time of Event
        Format:  FileMan Internal Format for date/time
 "PATIENT ED",i,"COMMENT")                                       Optional
        Comment
        Format:  Free Text field (1-245 characters)
 "PATIENT ED",i,"DELETE")                                        Optional
        This is a flag that denotes deletion of the Provider entry.
        Format:  [ 1 | null ]|
 "PATIENT ED",i,"DELETE")                                        Optional
        This is a flag that denotes deletion of the Patient Ed entry.
        Format:  [ 1 | null ]|
```

```
HEALTH FACTOR:   The "HEALTH FACTOR" node may have multiple entries (i). To
delete the entire "HEALTH FACTOR" entry, set the "DELETE" node to 1.

SUBSCRIPT DESCRIPTION:

 "HEALTH FACTOR",i,"HEALTH  FACTOR")                             Required
        Health Factor that contributes to a patient's state of health.
        Format:  Pointer to Health Factors file (9999999.64)
 "HEALTH FACTOR",i,"LEVEL/SEVERITY")                            Optional
        Level/Severity of health factor related to the patient's state of
            health.
        Format:  Set of Codes.
             M::=Minimal
             MO:=Moderate
             H:=Heavy/Severe
 "HEALTH FACTOR",i,"ENC PROVIDER")                              Optional
        Provider who documented the health factor.
        Format:  Pointer to New Person file (200)
```

```
 "HEALTH FACTOR",i,"EVENT D/T")                              Optional
      Date/Time of Event
      Format:  FileMan Internal Format for date/time
 "HEALTH FACTOR",i,"COMMENT")                                Optional
      Comment
      Format:  Free Text field (1-245 characters)
 "HEALTH FACTOR",i,"DELETE")                                 Optional
      This is a flag that denotes deletion of the Health Factor entry.
      Format:  [ 1 | null ]|


 EXAM:   The "EXAM" node may have multiple entries (i). To delete the entire
 "EXAM" entry, set the "DELETE" node to 1.

 SUBSCRIPT DESCRIPTION:

 "EXAM",i,"EXAM")                                            Required
      Exam that was performed.
      Format:  Pointer to Exam file (9999999.15)
 "EXAM",i,"RESULT")                                          Optional
      Result of Exam
      Format:  Set of Codes.
           A::=Abnormal
           N::=Normal
 "EXAM",i,"ENC PROVIDER")                                    Optional
      Provider who performed the exam..
      Format:  Pointer to New Person file (200)
 "EXAM",i,"EVENT D/T")                                       Optional
      Date/Time of Exam
      Format:  FileMan Internal Format for date/time
 "EXAM",i,"COMMENT")                                         Optional
      Comment
      Format:  Free Text field (1-245 characters)
 "EXAM",i,"DELETE")                                          Optional
      This is a flag that denotes deletion of the Exam entry.
      Format:  [ 1 | null ]|


 SKIN TEST:   The "SKIN TEST" node may have multiple entries (i). To delete
 the entire "SKIN TEST" entry, set the "DELETE" node to 1.

 SUBSCRIPT DESCRIPTION:

 "SKIN TEST",i,"TEST")                                       Required
      Skin Test that was performed
      Format:  Pointer to Skin Test file (9999999.28)
 "SKIN TEST",i,"READING")                                    Optional
      Numeric measurement of the surface area tested (in millimeters).
      Format:  Whole number between 0 and 40 inclusive.
 "SKIN TEST",i,"RESULT")                                     Optional
      Results of the Skin Test
      Format:  Set of Codes.
           P::=Positive
           D::=Doubtful
           N::=Negative
           O::=No Take
```

```
 "SKIN TEST",i,"D/T READ")                               Optional
     Date/time skin test was read
     Format:  FileMan Internal Format for date/time
 "SKIN TEST",i,"ENC PROVIDER")                           Optional
     Provider who read  the skin test.
     Format:  Pointer to New Person file (200)
 "SKIN TEST",i,"EVENT D/T")                              Optional
     Date/Time test was administered.
     Format:  FileMan Internal Format for date/time
 "SKIN TEST",i,"COMMENT")                                Optional
     Comment
     Format:  Free Text field (1-245 characters)
 "SKIN TEST",i,"DELETE")                                 Optional
     This is a flag that denotes deletion of the Skin Test entry.
     Format:  [ 1 | null ]|
```

```
 IMMUNIZATION:  The "IMMUNIZATION" node may have multiple entries (i). To
 delete the entire "IMMUNIZATION" entry, set the "DELETE" node to 1.
```

```
 SUBSCRIPT DESCRIPTION:
```

```
 "IMMUNIZATION",i,"IMMUN")                               Required
     Immunization that was performed.
     Format:  Pointer to Immunization file (9999999.14)
 "IMMUNIZATION",i,"SERIES")                              Optional
     Series specifies the sequence of the series for the immunization
         that was administered.
     Format:  Set of Codes.
         P::=Partially complete
         C::=Complete
         B::=Booster
         1::=Series1 thru 8::=Series8
 "IMMUNIZATION",i,"REACTION")                            Optional
     The observed reaction to the immunization.
     Format:  Set of Codes.
         0::=None
         1::=Fever
         2::=Irritability
         3::=Local Reaction or Swelling
         4::=Vomiting
         5::=Rash or Itching
         6::=Lethargy
         7::=Convulsions
         8::=Arthritis or Arthralgias
         9::=Anaphylaxis or Collapse
         10::=Respiratory Distress
         11::=Other
 "IMMUNIZATION",i,"CONTRAINDICATED")                     Optional
     This field may be used to indicate that this immunization should
         not be administered again.  "1" indcates that the immunization
         should not be given to the patient in the future.
     Format:  [ 1 | 0 | null ]
 "IMMUNIZATION",i,"ENC PROVIDER")                        Optional
     Provider who performed the immunization.
     Format:  Pointer to New Person file (200)
```

```
  "IMMUNIZATION",i,"EVENT D/T")                           Optional
      Date/Time immunization was administered.
      Format:  FileMan Internal Format for date/time
  "IMMUNIZATION",i,"COMMENT")                             Optional
      Comment
      Format:  Free Text  (1-245 characters)
  "IMMUNIZATION",i,"DELETE")                              Optional
      This is a flag that denotes deletion of the Immunization entry.
      Format:  [ 1 | null ]|
```

TREATMENT: The "TREATMENT" node may have multiple entries (i). To delete
the entire "TREATMENT" entry, set the "DELETE" node to 1.

SUBSCRIPT DESCRIPTION:

```
 "TREATMENT",i,"TREATMENT")                              Required
      Name of Treatment
      Format:  Pointer to Treatment file (9999999.17)
 "TREATMENT",i,"QTY")                                    Optional
      Number of times the treatment was performed.
      Format:  Whole number > 0
 "TREATMENT",i,"NARRATIVE")                             *Optional
      The provider's description of the treatment performed. *If
          NARRATIVE is not passed for a treatment, the Treatment Name
          from the Treatment file (9999999.17) will be used as the
          default.
      Format:  Free text (2-245 characters)
 "TREATMENT",i,"CATEGORY")                               Optional
      A term that denotes a grouping or category for a set of related
          treatments.
      Format:  Free text (2-245 characters)
 "TREATMENT",i,"ENC PROVIDER")                           Optional
      Provider who performed the treatment.
      Format:  Pointer to New Person file (200)
 "TREATMENT",i,"EVENT D/T")                              Optional
      Date/Time treatment was done.
      Format:  FileMan Internal Format for date/time
 "TREATMENT",i,"COMMENT")                                Optional
      Comment
      Format:  Free Text  (1-245 characters)
 "TREATMENT",i,"DELETE")                                 Optional
      This is a flag that denotes deletion of the Treatment entry.
      Format:  [ 1 | null ]|
```

EXAMPLE OF DATA PASSED TO $$DATA2PCE^PXAPI

Provided below is an example of data passed to $$DATA2PCE^PXAPI where
Laboratory is the ancillary package reporting the data.

$$DATA2PCE^PXAPI("LRPXAPI",$J,182,"LAB DATA")

This is an example where Laboratory passes two laboratory tests (Glucose
and CPK) which were resulted on 4/20/96 at 9:30 a.m. This occasion of
service is defined as an Ancillary Package Daily Data (X).

```
^TMP("LRPXAPI",543173595,"ENCOUNTER",1,"CREDIT STOP") = 59
^TMP("LRPXAPI",543173595,"ENCOUNTER",1,"ENC D/T") = 2960420.093
^TMP("LRPXAPI",543173595,"ENCOUNTER",1,"HOS LOC") = 59
^TMP("LRPXAPI",543173595,"ENCOUNTER",1,"PATIENT") = 1030
^TMP("LRPXAPI",543173595,"ENCOUNTER",1,"SERVICE CATEGORY") = X
^TMP("LRPXAPI",543173595,"PROCEDURE",1,"ENC PROVIDER") = 58
^TMP("LRPXAPI",543173595,"PROCEDURE",1,"EVENT D/T") = 2960420.093
^TMP("LRPXAPI",543173595,"PROCEDURE",1,"PROCEDURE") = 82950
^TMP("LRPXAPI",543173595,"PROCEDURE",1,"QTY") = 1
^TMP("LRPXAPI",543173595,"PROCEDURE",2,"ENC PROVIDER") = 58
^TMP("LRPXAPI",543173595,"PROCEDURE",2,"EVENT D/T") = 2960420.093
^TMP("LRPXAPI",543173595,"PROCEDURE",2,"PROCEDURE") = 82552
^TMP("LRPXAPI",543173595,"PROCEDURE",2,"QTY") = 1
^TMP("LRPXAPI",543173595,"PROVIDER",1,"NAME") = 58
^TMP("LRPXAPI",543173595,"PROVIDER",1,"PRIMARY") = 1
^TMP("LRPXAPI",543173595,"PROCEDURE",1,"PROCEDURE") =
^TMP("LRPXAPI",543173595,"PROCEDURE",1,"MODIFIERS",57) = ""
^TMP("LRPXAPI",543173595,"PROCEDURE",1,"QUANTITY") = 1


   ROUTINE: PXAPI
 COMPONENT:  DATA2PCE
 VARIABLES:

                    ********************


    2692     NAME: ORQPTQ1 calls
  CUSTODIAL PACKAGE: ORDER ENTRY/RESULTS REPORTING          Salt Lake City
SUBSCRIBING PACKAGE: CONSULT/REQUEST TRACKING               Salt Lake City
                  calls TEAMPROV
                  CLINICAL REMINDERS                        Salt Lake City
                  calls TEAMPTS
                  GEN. MED. REC. - VITALS                   Chicago
                  Calls TEAMS and TEAMPTS.
                  KERNEL
                  CLINICAL PROCEDURES
              USAGE: Controlled Subscri  ENTERED: JAN  2,1999
             STATUS: Active               EXPIRES:
           DURATION: Till Otherwise Agr  VERSION:
        DESCRIPTION:                      TYPE: Routine
 ORQPTQ1 provides entry points to provide patient lists by providers, etc.
 This DBIA will include those calls being used by outside packages.

   ROUTINE: ORQPTQ1
 COMPONENT:  TEAMPROV(.ARRAY,TEAMIEN)
             Input an OE/RR team IEN and receive back an array of provides
             linked to the team.
 VARIABLES:  Output    ARRAY
                    Return array as follows:

                        ARRAY(#) = New Person IEN ^ New Person Name
 VARIABLES:  Input     TEAMIEN
                    IEN of OE/RR LIST file (#100.21)
 COMPONENT:  TEAMS(.ARRAY)
             Input name of array and receive back all OE/RR LIST file
             (#100.21) IENS and names.  If no entries in FILE 100.21, then
             return: ARRAY(1) = "^No teams found."
```

```
VARIABLES:  Both      ARRAY
                      Name of the array to return data in. Return array
                      as follows: ARRAY(#) = FILE 100.21 IEN ^ FILE
                      100.21 NAME (.01)
COMPONENT:  TEAMPTS(.ARRAY,TEAM)
            Input name of array and OE/RR LIST file (#100.21) IEN. Receive
            back all patient DFNs and names associated with that FILE
            100.21 entry. If no entries, then return: ARRAY(1) = "^No
            patients found."
VARIABLES:  Both      ARRAY
                      Name of the array to return data in. Return array
                      as follows: ARRAY(#) = DFN ^ FILE 2 NAME (.01)
VARIABLES:  Input     TEAM
                      IEN for a FILE 100.21 entry.
      KEYWORDS:
```

****

```
   2693    NAME: TIULQ calls
 CUSTODIAL PACKAGE: TEXT INTEGRATION UTILITIES              Salt Lake City
SUBSCRIBING PACKAGE: CONSULT/REQUEST TRACKING               Salt Lake City
                    LAB SERVICE
                    SURGERY                                 Birmingham
                    CLINICAL PROCEDURES
                    ORDER ENTRY/RESULTS REPORTING
           USAGE: Controlled Subscri  ENTERED: JAN  2,1999
          STATUS: Active              EXPIRES:
        DURATION: Till Otherwise Agr  VERSION:
     DESCRIPTION:                     TYPE: Routine
 Entry points in this routine provide extract mechanisms for TIU records.

   ROUTINE: TIULQ
 COMPONENT:  EXTRACT(TIUDA,TIUROOT,TIUERR,DR,TIULINE,TIUTEXT,FORMAT,OVRRIDE)
             Call to retrieve record and addenda
 VARIABLES:  Input     TIUDA
                       Internal entry number of note in TIU DOCUMENT file
                       (#8925).  [REQUIRED]
 VARIABLES:  Input     TIUROOT
                       Root of the array in which data should be
                       returned.  [OPTIONAL]

                       (set to "^TMP(""TIULQ"",$J)" if not defined on
                       entry).
 VARIABLES:  Output    TIUERR
                       Error message in format 1^message
 VARIABLES:  Input     DR
                       List of field numbers to return values for.
                       [OPTIONAL]

                       (set to ".01:.1;1201:1701" if not defined on
                       entry)
 VARIABLES:  Input     TIULINE
                       Offset line number [OPTIONAL]
 VARIABLES:  Input     TIUTEXT
                       1 returns report text.  [OPTIONAL]
```

```
   VARIABLES:  Input     FORMAT
                           Set as input parameter for format as accepted by
                           EN^DIQ1.  [OPTIONAL]

                           (set to "IE" if not defined on entry)
   VARIABLES:  Input     OVRRIDE
                           Override ability of user to print record text.
                           [OPTIONAL]
           KEYWORDS:

                           ********************

      ³2926     NAME: GMRCGUIA
  CUSTODIAL PACKAGE: CONSULT/REQUEST TRACKING               Salt Lake City
SUBSCRIBING PACKAGE: ORDER ENTRY/RESULTS REPORTING          Salt Lake City
                    PROSTHETICS                             Chicago
                    CARE MANAGEMENT
                    CLINICAL PROCEDURES
                        Permitted to use the RT entry point component only.
             USAGE: Controlled Subscri  ENTERED: OCT 13,1999
            STATUS: Active               EXPIRES:
          DURATION: Till Otherwise Agr  VERSION:
       DESCRIPTION:                      TYPE: Routine
  This DBIA documents calls to GMRCGUIA.

    ROUTINE: GMRCGUIA
  COMPONENT:  RT(IEN,ARRAY)
              Returns narrative for a consult result report
  VARIABLES:  Input     IEN
                           IEN of request in the REQUEST/CONSULTATION file
                           (#123)
  VARIABLES:  Both      ARRAY
                           Name of the array in which to return the text of
                           the report as ARRAY(#,0)=line of text
  COMPONENT:  $$DC(IEN,PROVIDER,DATETIME,STATUS,.COMMENT)
              Entry point to discontinue or deny a consult request.
  VARIABLES:  Input     IEN
                           IEN of REQUEST/CONSULTATION file (#123)
  VARIABLES:  Input     PROVIDER
                           Pointer to NEW PERSON file (#200) denoting
                           provider who discontinued or denied the consult
                           request.
  VARIABLES:  Input     DATETIME
                           Date/time the actual activity (discontinuation or
                           denial) took place.
  VARIABLES:  Input     STATUS
                           DY if Cancelled (previously 'deny') DC if
                           Discontinued
  VARIABLES:  Input     .COMMENT
                           Array of comment containing explanation of denial
                           or discontinuation.
```

---

[3] Patch MD*1*2 July 2004 DBIA added.

```
VARIABLES: Output    OUTPUT
                       Extrinsic function returns:
                       ErrorFlag^ErrorMessage

                       ErrorFlag is 0 if no error found or 1 if an errror
                       occured.  ErrorMessage is null for no error or
                       descriptive of error if one occurred.
COMPONENT: $$FR(IEN,SERVICE,PROVIDER,ATTENTION,URGENCY,.COMMENT,DATETIME)
           Call to forward an existing consult to a different service.
VARIABLES: Input     IEN
                       IEN of REQUEST/CONSULTATION file (#123)
VARIABLES: Input     SERVICE
                       Pointer to REQUEST SERVICES file (#123.5)
                       indicating service consult request should be
                       forwarded to.
VARIABLES: Input     PROVIDER
                       Pointer to NEW PERSON file (#200) indicating
                       provider responsible for the forwarding action.
VARIABLES: Input     ATTENTION
                       Pointer to NEW PERSON file (#200) indicating the
                       person to whose attention the forwarded consult
                       should be directed.
VARIABLES: Input     URGENCY
                       Value of the URGENCY from the PROTOCOL file (#101)
VARIABLES: Input     .COMMENT
                       Array of comments that explains the reason the
                       request was forwarded.
VARIABLES: Input     DATETIME
                       The date/time the request was forwarded
VARIABLES: Output    OUTPUT
                       Extrinsic function returns:
                       ErrorFlag^ErrorMessage

                       ErrorFlag is 0 if no error found or 1 if an errror
                       occured.  ErrorMessage is null for no error or
                       descriptive of error if one occurred.
COMPONENT: $$RC(IEN,RECEIVER,DATETIME,.COMMENTS,ENTERER)
           Call to receive a consult into a service
VARIABLES: Input     IEN
                       IEN of REQUEST/CONSULTATION file (#123)
VARIABLES: Input     RECEIVER
                       Pointer to NEW PERSON file (#200) denoting person
                       who received the consult request.
VARIABLES: Input     DATETIME
                       Actual date/time the consult was received by the
                       service
VARIABLES: Input     COMMENTS
                       Array of comments entered for request
VARIABLES: Input     ENTERER
                       IEN of NEW PERSON file (#200) indicating person
                       who entered consult as being received.
```

```
       VARIABLES:  Output     OUTPUT
                             Extrinsic function returns:
                             ErrorFlag^ErrorMessage

                             ErrorFlag is 0 if no error found or 1 if an errror
                             occured.  ErrorMessage is null for no error or
                             descriptive of error if one occurred.
            KEYWORDS:

                        ********************

    2944    NAME: Calls to TIUSRVR1
 CUSTODIAL PACKAGE: TEXT INTEGRATION UTILITIES                Salt Lake City
SUBSCRIBING PACKAGE: CLINICAL PROCEDURES
            USAGE: Controlled Subscri  ENTERED: OCT 29,1999
           STATUS: Active               EXPIRES:
         DURATION: Till Otherwise Agr  VERSION:
             FILE:                        ROOT:
      DESCRIPTION:                        TYPE: Routine
  This DBIA documents calls to TIUSRVR1.

    ROUTINE: TIUSRVR1
  COMPONENT:  TGET(.GLOBAL,IEN,ACTION)
  VARIABLES:  GLOBAL       Both
                                 The global location of the returned data
                                 (^TMP("TIUVIEW",$J)) is returned in this
                                 variable which is passed by reference.
              IEN          Input
                                 The IEN of the record from the TIU
                                 DOCUMENT file.
              ACTION       Input
                                 This optional String type parameter
                                 identifies the action (e.g., PRINT, or
                                 VIEW) that the user is attempting to
                                 execute (DEFAULT: VIEW).
                     This API returns the textual portion of a TIU document
                     Record.

                     It's also callable via RPC TIU GET RECORD TEXT.

                        ********************

    2981    NAME: Calls to GMRCP5
 CUSTODIAL PACKAGE: CONSULT/REQUEST TRACKING                  Salt Lake City
SUBSCRIBING PACKAGE: CLINICAL PROCEDURES                      Chicago
            USAGE: Controlled Subscri  ENTERED: NOV 12,1999
           STATUS: Active               EXPIRES:
         DURATION: Till Otherwise Agr  VERSION:
             FILE:                        ROOT:
      DESCRIPTION:                        TYPE: Routine
  This DBIA documents calls made to routine GMRCP5.

    ROUTINE: GMRCP5
  COMPONENT:  GUI(.ROOT,IEN)
```

```
   VARIABLES:  IEN          Input
                                     IEN of REQUEST/CONSULTATION file (#123)
                                     for which report should be returned.
                    Returns SF513 report for display in GUI environment.  Root
                    will be set to ^TMP("GMRC",$J,"SF513").
   COMPONENT:  EN(IEN,COPYTYPE,DEVICE,.STATUS)
   VARIABLES:  IEN          Input
                                     IEN of REQUEST/CONSULTATION file (#123).

               COPYTYPE     Input
                                     C for Chart Copy W for Working Copy null
                                     for not applicable
               DEVICE       Input
                                     Device to be passed to %ZTLOAD as ZTIO.
               STATUS       Output
                                     Returned as:
                                       0^Queued as task # n   (if successful)
                                      -1^Not Queued           (if
                                     unsuccessful)
                    Entry point to send a copy of the SF513 to a printer
                    device.

                         ********************
```

```
      ⁴3067     NAME: DBIA3067
  CUSTODIAL PACKAGE: CONSULT/REQUEST TRACKING                 Salt Lake City
SUBSCRIBING PACKAGE: CLINICAL PROCEDURES                      Chicago
              USAGE: Private              ENTERED: MAR 16,2000
             STATUS: Active               EXPIRES:
           DURATION: Till Otherwise Agr   VERSION:
               FILE: 123                     ROOT: GMR(123,
        DESCRIPTION:                         TYPE: File
    PURPOSE: Provide Clinical Procedures with a way to display Consult
    Procedure order information.
    GLOBAL REFERENCE:
      ^GMR(123,
        5         URGENCY             0;9      Read w/Fileman
        20        REASON FOR REQUEST  20;0     Read w/Fileman
        30.1      PROVISIONAL DIAGNOSI 30.1;1  Read w/Fileman
        8         CPRS STATUS         0;12     Read w/Fileman
           KEYWORDS:

                         **************************
```

```
     3162     NAME: POINT TO REQUEST/CONSULTATION (#123) FILE
  CUSTODIAL PACKAGE: CONSULT/REQUEST TRACKING                 Salt Lake City
SUBSCRIBING PACKAGE: CLINICAL PROCEDURES                      Chicago
              USAGE: Controlled Subscri  ENTERED: AUG  9,2000
             STATUS: Active               EXPIRES:
           DURATION: Till Otherwise Agr   VERSION:
               FILE: 123                     ROOT: GMR(123,
        DESCRIPTION:                         TYPE: File
    This Integration Agreement documents the clinical packages that have
    permission to point to the REQUEST/CONSULTATION (#123) file.
```

---

⁴ Patch MD*1*2 July 2004 DBIA added.

```
    ROUTINE:

                        ********************

     3266    NAME: DBIA 3266
  CUSTODIAL PACKAGE: REGISTRATION
SUBSCRIBING PACKAGE: CLINICAL PROCEDURES
            USAGE: Controlled Subscri  ENTERED: DEC  5,2000
           STATUS: Active                EXPIRES:
         DURATION: Till Otherwise Agr  VERSION:
             FILE:                       ROOT:
      DESCRIPTION:                       TYPE: Routine
  The patient lookup routine, DPTLK1, has a useful api for obtaining a
  formated date of birth.  Imaging is requesting permission to use this api.

    ROUTINE: DPTLK1
  COMPONENT:  $$DOB(DFN,DGYR)
  VARIABLES: DFN          Input
                                 Patient's DFN.
             DGYR         Input

                                 If input value is:
                                        0 - returns 4-digit year
                                 (default)
                                        1 - returns 2-digit year
                                        2 - returns filemanager date

                                 output DOB = mm/dd/yyyy (default)
                                            = mm/dd/yy, if DGYR=1
                                            = yyymmdd, if DGYR=2
                     Calling routine passes the Patient's DFN and obtains the
                     corresponding date of birth for that patient. If the
                     patient's primary eligibility is 'Employee' then
                     "SENSISTIVE" is passed in place of the date of birth.

                        ********************

     3267    NAME: DBIA 3267
  CUSTODIAL PACKAGE: REGISTRATION
SUBSCRIBING PACKAGE: CLINICAL PROCEDURES
            USAGE: Controlled Subscri  ENTERED: DEC  5,2000
           STATUS: Active                EXPIRES:
         DURATION: Till Otherwise Agr  VERSION:
             FILE:                       ROOT:
      DESCRIPTION:                       TYPE: Routine
  The patient lookup routine, DPTLK1, has a useful api for obtaining the
  patient's social security number.  Imaging is requesting permission to use
  this api.

    ROUTINE: DPTLK1
  COMPONENT:  SSN
  VARIABLES: DFN          Input
                                 Patient's dfn
                On a given patient will display the patient's ssn
                identifier; except for employees.

                        ********************
```

```
    3376    NAME: DBIA3376
  CUSTODIAL PACKAGE: TEXT INTEGRATION UTILITIES                Salt Lake City
SUBSCRIBING PACKAGE: CLINICAL PROCEDURES                       Chicago
              USAGE: Controlled Subscri  ENTERED: MAY 14,2001
             STATUS: Active                EXPIRES:
           DURATION: Till Otherwise Agr   VERSION:
               FILE: 8925               ROOT: TIU(8925,DA,0)
        DESCRIPTION:                     TYPE: File
  This IA will document the fact that in the CP TRANSACTION file (#702) has
  a field called TIU NOTE (Field #.06) which points to the TIU DOCUMENT file
  (#8925).
    ^TIU(8925,DA,0)
     .01    DOCUMENT TYPE         0;1      Pointed to

    ROUTINE:
```

```
                        ********************
```

```
    3377    NAME: DBIA3377
  CUSTODIAL PACKAGE: TEXT INTEGRATION UTILITIES                Salt Lake City
SUBSCRIBING PACKAGE: CLINICAL PROCEDURES                       Chicago
              USAGE: Private               ENTERED: MAY 14,2001
             STATUS: Active                EXPIRES:
           DURATION: Till Otherwise Agr   VERSION:
               FILE: 8925.1             ROOT: TIU(8925.1,DA,0)
        DESCRIPTION:                     TYPE: File
  This IA is to document the fact that the CP DEFINITION file (#702.01) has
  a field called DEFAULT TIU NOTE (Field #.04) which points to the TIU
  DOCUMENT DEFINITION file (#8925.1).
    ^TIU(8925.1,DA,0)
     .01    NAME                  0;1      Pointed to

    ROUTINE:
```

```
                        ********************
```

```
    3468    NAME: CLINICAL PROCEDURE UTILITIES
  CUSTODIAL PACKAGE: CONSULT/REQUEST TRACKING                  Salt Lake City
SUBSCRIBING PACKAGE: CLINICAL PROCEDURES                       Chicago
              USAGE: Controlled Subscri  ENTERED: OCT 10,2001
             STATUS: Active                EXPIRES:
           DURATION: Till Otherwise Agr   VERSION:
               FILE:                     ROOT:
        DESCRIPTION:                     TYPE: Routine
  This integration agreement describes several utilities used to gather
  information or update Consult records involved in the Clinical Procedures
  interface to Consult/Request Tracking.

    ROUTINE: GMRCCP
  COMPONENT:  CPLIST(GMRCPT,GMRCPR,GMRCRET)
  VARIABLES:  GMRCPT        Input
                              This is the patient identifier (DFN).

              GMRCPR        Input

                              This optional variable is a pointer to
                              the CP DEFINITION (#702.01) file. If this
                              variable is not passed, all CP requests
                              will be returned.
```

	GMRCRET	Output	

> This required variable is the name of a global array in which to return the list of CP requests for a patient.
>
> The array is returned in the format:
>
> ^global(array)= a^b^c^d^e^f
>
> where: a=date of request b=CP DEFINITION name c=urgency d=status e=consult ien from file 123 f=CP DEFINITION ien

This entry point returns a list of Clincial Procedure requests on file for a given patient.

COMPONENT: $$CPDOC(GMRCDA,TIUDA,ACTION)
VARIABLES: GMRCDA   Input

> This required variable is the file 123 ien.

TIUDA   Input

> This required variable is the ien from the TIU DOCUMENT (#8925) file that is to be updated in the consult request (GMRCDA).

ACTION   Input

> This required variable is teh activity to take on the consult using the TIU document.
>
> The only current implementation is the value of 2 which will update the consult to partial results and attach the TIU document with the Clinical Procedure request.

$$CPDOC   Output

> This output variable will return:
>
> 1   = successful 0^error = unsuccessful^problem

This entry point updates REQUEST/CONSULTATION (#123) file entries by attaching a TIU document as a result.

COMPONENT: $$CPLINK(PROC)
VARIABLES: PROC   Input

> This required variable is a pointer to the CP DEFINITION (#702.01) file.

$$CPLINK   Output

> The output of this entry point will be in the form:
>
> 1 = currently linked to a GMRC PROCEDURE (#123.3) file entry 0 = not currently linked to a GMRC PROCEDURE (#123.3) file entry

This entry point is used to determine if a given CP DEFINITION (#702.01) file entry is linked to any entry in the GMRC PROCEDURE (#123.3) file.

COMPONENT: CPLINKS(.NAMES,PROC)

VARIABLES: NAMES   Output

                           This variable is passed by reference and
                           is returned as array of GMRC PROCEDUREs
                           linked to a given CP DEFINITION in
                           format:

                                   NAMES(x)=GMRC PROCEDURE name^GMRC
                           PROCEDURE ien
                                   NAMES(1)="EKG^21"
                                   NAMES(2)="EKG PORTABLE^32"

                                   if not currently linked, returned
                           as:
                                   NAMES(1)="-1^not currently
                           linked"
             PROC   Input

                           This required variable is pointer to the
                           CP DEFINITION (#702.01) file.
               This entry point returns a list of the GMRC PROCEDURE
               (#123.3) file entries linked to a given CP DEFINITION.

                           ****

      3535   NAME: TIUSRVP Calls
 CUSTODIAL PACKAGE: TEXT INTEGRATION UTILITIES   Salt Lake City
SUBSCRIBING PACKAGE: CLINICAL PROCEDURES
             USAGE: Controlled Subscri ENTERED: MAR 1,2002
            STATUS: Active   EXPIRES:
          DURATION: Till Otherwise Agr VERSION:
              FILE: ROOT:
       DESCRIPTION: TYPE: Routine
  Entry points in this routine provide mechanisms for creating, updating,
  deleting and addending TIU records.

    ROUTINE: TIUSRVP
  COMPONENT: MAKE(SUCCESS,DFN,TITLE,VDT,VLOC,VSIT,TIUX,VSTR,SUPPRESS,NOASF)
 VARIABLES: DFN   Input
                           This REQUIRED PARAMETER is the pointer to
                           the patient file.
             TITLE   Input
                           This is the pointer to the TIU DOCUMENT
                           DEFINITION FILE which identifies the
                           TITLE of the document to be filed.
             VDT   Used
                           This optional parameter is the Date/time
                           of visit. If the parameter VSIT is
                           present, this will be ignored.
                           Otherwise, the RPC will attempt to
                           generate a match with a visit based on
                           DFN, VDT, and VLOC (visit location). In
                           the event that the RPC cannot generate
                           such a match, a new EVENT-type Visit will
                           be created with the current date/time.
             VLOC   Used
                           This optional parameter is the Location
                           of Visit (e.g., Cardiology Clinic). It
                           is a pointer to Hospital location (File
                           #44).

VSIT	Used	
		This is a pointer to the Visit File (#9000010) entry for the visit to which the document is to be linked.
TIUX	Input	
		This is the input array in which the identifiers of the document, as well as its text, are to be stored in the following format:

```
 TIUX(.02)=45678
 TIUX(1301)=2960703.104556
 TIUX(1302)=293764
 TIUX("TEXT",1,0)="The patient is a 70
year old WHITE MALE, who presented
 to the ONCOLOGY CLINIC"
 TIUX("TEXT",2,0)="On JULY 3, 1996@10:00
AM, with the chief complaint of
 NECK PAIN..."
```

VSTR	Used	
		This parameter identifies the visit location, date/time, and Service Category (Hospitalization, Ambulatory, Telecommunications, or Event (HISTORICAL)) in the form of a semi-colon delimited string (e.g., "469;2970616.1415;A").
SUPPRESS	Used	
		BOOLEAN flag indicating whether or not to suppress execution of the COMMIT ACTION for the document in question. This gives the calling application control over the circumstances in which the COMMIT CODE should be executed.
NOASF	Used	
		This parameter can optionally be set to 1 to indicate the ASAVE cross-reference in the TIU Document file (#8925) should not be set when call is made. The intent of this cross-reference is for telnet type sessions where a user could be dropped. The cross-reference is used to provide the user with an easy way to resume editing the TIU Document they were working on when they were dropped. In the Clinical Procedures realm, for example, where the stub is created in the 'background' this cross-reference should not be set since the user is not interactively involved in the creation of the record.

                      SUCCESS   Both
                                          If the call is successful, this will be
                                          the record number (IEN) of the resulting
                                          entry in the TIU DOCUMENT FILE (#8925).
                                          In the event of a filing error, the first
                                          "^"-piece will be zero, and the second
                                          "^"-piece of this scalar return variable
                                          will be a textual message describing the
                                          nature of the error (e.g., 0^Invalid
                                          TITLE Selected.").
              This entry point allows the creation of TIU DOCUMENT
              records.
    COMPONENT: UPDATE(SUCCESS,TIUDA,TIUX,SUPPRESS)
    VARIABLES: SUCCESS   Both
                                          This is the return parameter, which is
                                          passed by reference. If an error occurs,
                                          it will be a pointer to the FM dialog
                                          file followed by the integer 1 in the
                                          second "^"-piece (e.g., 8925001^1).
                      TIUDA   Input
                                          This is the record # (IEN) of the TIU
                                          Document in file #8925.
                      TIUX   Input
                                          This is the input array which contains
                                          the data to be filed in the modified
                                          document. It should look something like
                                          this:

                                           TIUX(.02)=45678
                                           TIUX(1301)=2960703.104556
                                           TIUX(1302)=293764
                                           TIUX("TEXT",1,0)="The patient is a 70
                                          year old WHITE MALE, who presented
                                           to the ONCOLOGY CLINIC"
                                           TIUX("TEXT",2,0)="On JULY 3, 1996@10:00
                                          AM, with the chief complaint of
                                           NECK PAIN..."
                      SUPPRESS   Used
                                          This BOOLEAN Flag is passed in to
                                          suppress the call to the COMMIT CODE for
                                          the TIU DOCUMENT in question (i.e.,
                                          SUPPRESS=1 ==> don't execute commit code;
                                          SUPPRESS=0 or UNDEFINED ==> DO execute
                                          commit code).
              This API updates the record named in the TIUDA parameter,
              with the information contained in the TIUX(Field #) array.
              The body of the modified TIU document should be passed in
              the TIUX("TEXT",i,0) subscript, where i is the line number
              (i.e., the "TEXT" node should be ready to MERGE with a word
              processing field). Any filing errors which may occur will
              be returned in the single valued ERR parameter (which is
              passed by reference).
    COMPONENT: DELETE(ERR,TIUDA,TIURSN,OVRRIDE)
    VARIABLES: TIUDA   Input
                                          Record number of TIU Document to be
                                          deleted.

```
          TIURSN      Used
                                  This optional parameter specifies the
                                  reason for deletion (i.e., Privacy Act,
                                  or Administrative Action). It only needs
                                  to be passed if the document has already
                                  been signed, and the user is still
                                  authorized to delete the record.
          ERR         Output
                                  Returns error message with
                                  ERR=1^Explanation text if the user is NOT
                                  authorized to delete the named record
                                  (e.g., it's his, but signed; or it's not
                                  his, and he better keep his paws off it).
          OVRRIDE     Input
                                  This optional BOOLEAN parameter indicates
                                  to the API whether the business rules
                                  defined by the site for the DELETE action
                                  should be overridden for the document in
                                  question. Allowable values are 1 (TRUE),
                                  or 0 (FALSE). DEFAULT is 0 (FALSE).
                    Deletes TIU Document records...Evaluates authorization.
    COMPONENT:  MAKEADD(TIUDADD,TIUDA,TIUX,SUPPRESS)
    VARIABLES:  TIUDA       Input
                                  This is the record number of the parent
                                  document in file 8925.
          TIUX        Input
                                  This is a local input array containing
                                  the data to be filed for the addendum
                                  record, formatted as follows:

                                   TIUX(.02)=45678
                                   TIUX(1301)=2960703.104556
                                   TIUX(1302)=293764
                                   TIUX("TEXT",1,0)="The patient is a 70
                                  year old WHITE MALE, who presented
                                   to the ONCOLOGY CLINIC"
                                   TIUX("TEXT",2,0)="On JULY 3, 1996@10:00
                                  AM, with the chief complaint of
                                   NECK PAIN..."
          SUPPRESS    Used
                                  BOOLEAN flag indicating whether or not to
                                  suppress execution of the COMMIT ACTION
                                  for the document in question. This gives
                                  the calling application control over the
                                  circumstances in which the COMMIT CODE
                                  should be executed.
          TIUDADD     Both
                                  This is the record number of the
                                  resulting addendum.

                                  NOTE:  If no addendum record may be
                                  created, then the return variable will
                                  look as follows:  "-1^Could not create
                                  addendum."
                  This call allows the creation of addenda to TIU Documents.
```

****

```
      3567     NAME: Imaging - MAGGSIUI
 CUSTODIAL PACKAGE: IMAGING                                  Washington
SUBSCRIBING PACKAGE: CLINICAL PROCEDURES                       Chicago
                     Clinical Procedures is using the Imaging Import
                     Component to import images from a Medical device into
                     the VistA database.
             USAGE: Controlled Subscri  ENTERED: APR 26,2002
            STATUS: Active               EXPIRES:
          DURATION: Till Otherwise Agr  VERSION:
              FILE:                         ROOT:
       DESCRIPTION:                         TYPE: Routine
```

Imaging v3.0 patch MAG*3.0*7 introduces an Image Import API that can be
used to automatically import image files into VistA Imaging. The image
files can be from a medical device (instrument) or a network or local
drive. Once image files are imported, they are available for display from
the VistA Imaging Clinical Display application.

Importing image/report files is a two step process:

Step 1: The calling program initiates the import proces by sending an
input array to the Import API. The import API uses the input array to
create an entry in the Import Queue file and returns a status array to the
calling program.

Step 2: After the entries in the Import Queue file are processed (by the
Background Processor residing on the network), the Import API reports back
to the calling program in a result array.

Note: The Import API, as part of the VistA Imaging software, is regulated
as a medical device. The Import API cannot be used without a written
agreement between the VistA Imaging SD&D group and the party wishing to
use the Import API.

To secure an agreement for the use of the Import API, the following
criteria must be met:

1)   Any products built or interfaced using the VistA Imaging Import
API must be tested with VistA Imaging. Testing will be performed by the
VistA Imaging team with assistance from field sites and the calling
package. This testing must demonstrate that there are no adverse
interactions affecting the safety, efficacy or performance of the VistA
Imaging software or the devices interfaced to VistA Imaging.

2)   Any changes to packages/product(s) using the VistA Imaging Import
API must be reported to the VistA Imaging Project Office for review and
testing before release. Retesting of VistA Imaging with the product(s) is
required with any change.

3)   Documentation that imported reports/objects meet VHA, regulatory, and quality requirements must be on file with the Vista Imaging Project Office prior to any clinical use. Sample imported reports/objects shall be provided initially to the VistA Imaging Project Office by the package using the API. Sites installing the VistA Imaging API must comply with all VistA Imaging requirements and are responsible for filing all required documentation with the VistA Imaging Project Office, including image quality and data forms and sample reports/objects from any interfaced device.

4)   Additional requirements may apply to non-VA software using the Import API.

```
   ROUTINE: MAGGSIUI
COMPONENT:  IMPORT
VARIABLES:  MAGRY        Output
```
The status of the call will be returned in an array. Two examples are given below.

Example 1: Successful Queue
MAGRY(0)="111^Data has been Queued."
 A Background Processor Import Queue Number '^' message is returned in the (0) node. No other nodes are defined.

Example 2: unsuccessful Queue

 MAGRY (0)="0^Required parameter is null"
 MAGRY (1)="Tracking ID is Required. !"
 MAGRY (2)="Status Handler is Required. !"
 MAGRY (3)="Acquisition Site is Required. !"

 node (0) = 0 '^' Error message
 node(1..n)= all error messages incurred during validation.

```
            IMAGES       Input
```
An array of fully qualified file names. Each entry is the full path of the Image using UNC notation, and optionally a short description of the Image as the second '^' piece. If the array entry doesn't contain a short description as the 2nd '^' piece, the API will generate a default image short description from the procedure and procedure date. All images in the array will be saved as a group of images. If the array only contains 1 image, it will be saved as a single image.

```
                              The following is an example of an input
                              array:
                               IMAGES(1)="\\image server\image
                              share\filename.ext^image description"
                               IMAGES(2)="\\image server\image
                              share\filename2.ext"
                               IMAGES(3)="\\image server\image
                              share\filename3.ext^image description"
                               IMAGES(4)="\\image server\image
                              share\filename4.ext"
          MAGIX        Input
                              An array of predefined 'nodes' and data.
```

**CLINICAL PROCEDURES Integration Agreements subscribed to

```
                              Example:

                               MAGIX("ACQD")="COMPUTER AT EDS"
                               MAGIX("ACQL")=99
                               MAGIX("ACQS")=688
                               MAGIX("DOCCTG")=19
                               MAGIX("DOCDT")="05/05/1999"
                               MAGIX("IDFN")=1033
                               MAGIX("STSCB")="TESTCB^MAGGSIUI"
                               MAGIX("TRKID")="GK;101"

                              The following are possible predefine
                              nodes that can be passed; please note
                              that the items with an asterick (*) are
                              required information.


                              ACQD* -  Acquisition Device:  'Computer
                              Name' of Device (Domain Name for non-NT).

                              ACQL -   Hospital Location:  Pointer to
                              VistA Hospital Location File.

                              ACQS* -  Acquisition Site: Pointer to
                              VistA Institution File.

                              CDUZ  -  DUZ of person capturing the
                              image.

                              CMTH  -  Call Method: A Method to call
                              that will generate the image(s) (Note:
                              Either an 'Image Array' or a 'Call
                              Method' is required).

                              DFLG  -  Delete Flag:  '1' if images
                              should be deleted after successful
                              processing   (The default is '0', No
                              Deletion).
```

DOCCTG - Document Category: Pointer to VistA MAG DESCRPTIVE CATEGORIES file.

DOCDT - Document Date: (FileMan External or Internal Date)

GDESC - Short Description for the Image or Image Group (60 chars)

IDFN* - VistA Patient DFN

IMAGE - Full path of image in UNC notation ^ Optional Image Description

ITYPE - Image Type: The type of image (file extension); please consult Imaging for the different file types currently supported.

PASSWORD - Encrypted Password for the network\machine where the import image is located.

PXDT - Procedure Date/Time (FileMan External or Internal Date Time)

PXIEN - Procedure IEN

PXPKG - Procedure Package

STSCB* - Status Handler: "Tag^Routine" of initiating package. Imaging will call this to return the resulting status of the Import process.

TRKID* - Tracking ID = PackageID_;_unique identifier Example: "DOC;453"

TRTYPE - Transaction Type: 'NEW' or 'MOD' or 'DEL'   (TRYTPE is for Future use. Any value is ignored, it defaults to 'NEW'.)

USERNAME - Username for the network or machine where the import image resides.

This API receives imported images from an application. The API will return an array indicating whether the transaction was successful or unsuccessful.

****

```
     3568      NAME: DBIA3568
 CUSTODIAL PACKAGE: TEXT INTEGRATION UTILITIES              Albany
SUBSCRIBING PACKAGE: CLINICAL PROCEDURES                    Chicago
                     Clinical Procedures will use the LNGCP API to get a
                     selectable longlist of TIU Document titles for
                     Clinical Procedures.
             USAGE: Private              ENTERED: AUG  7,2003
            STATUS: Active               EXPIRES:
          DURATION: Till Otherwise Agr   VERSION:
              FILE:                          ROOT:
       DESCRIPTION:                          TYPE: Routine
  Clinical Procedures API(s)


    ROUTINE: TIUCP
  COMPONENT: LNGCP
  VARIABLES: Y             Output
                                 Array of 44 nearest Titles to that
                                 indicated by the user in the direction
                                 passed.
             FROM          Input
                                 Reference Titles from which the longlist
                                 is scrolling.
             DIR           Input
                                 Direction from which the longlist is
                                 scrolling from the reference Title.
              This API returns a longlist of titles for the Clinical
              Procedures CLASS.
  COMPONENT: ISCP
  VARIABLES: TITLE         Input
                                 The IEN for TIU Document Definition file
                                 (#8925.1).
             TIUY          Output
                                 Return value is 1 or 0; a one will
                                 indicate that the input value (TITLE) is
                                 defined as a Clinical Procedure.
              This API returns a true/false whether the TIU title is
              under the Clinical Procedures class.


                         *******************


     3869      NAME:  APPOINTMENT DATA BY CLINIC
 CUSTODIAL PACKAGE: SCHEDULING
SUBSCRIBING PACKAGE: GEN. MED. REC. - VITALS
                     ORDER ENTRY/RESULTS REPORTING
                     CLINICAL PROCEDURES
                     CLINICAL REMINDERS
                     REGISTRATION
             USAGE: Controlled Subscri  ENTERED: JAN  8,2003
            STATUS: Active               EXPIRES:
          DURATION:                      VERSION:
       DESCRIPTION:                          TYPE: Routine
  This IA contains a list of the supported calls for interaction with
  Appointment data contained in the Patient sub-file 2.98 and the Hospital
  Location appointment sub-file 44.001.  This IA is associated with
  Scheduling patch SD*5.3*275, to be released to NVS on 1/10/03.
```

```
    ROUTINE: SDAMA202
  COMPONENT: GETPLIST
             A call to this entry point will return appointment data for a
             specific clinic.
  VARIABLES: Input    SDIEN
                        Clinic ID
  VARIABLES: Input    SDFIELDS
                        Appointment fields requested
  VARIABLES: Input    SDAPSTAT
                        Appointment Status filter (optional parameter)
  VARIABLES: Input    SDSTART
                        Start date for appointment search (optional
                        parameter)
  VARIABLES: Input    SDEND
                        End date for appointment search (optional
                        parameter)
  VARIABLES: Input    .SDRESULT
                        Variable to contain the count of returned
                        appointments (optional parameter)
  VARIABLES: Input    SDIOSTAT
                        Patient Status filter (optional parameter)
  VARIABLES: Output   SDRESULT
                        A count of the returned appointments
  VARIABLES: Output   TMP($J,SDAMA202,GETPLIST)
                        The output array
                        ^TMP($J,"SDAMA202","GETPLIST",X,Y) will contain
                        the requested appointment data.  Output array
                        ^TMP($J,"SDAMA202","GETPLIST","ERROR",error_code)
                        will contain any errors that were generated.

                        The calling application is responsible for
                        deleting the temporary globals when they have
                        finished processing the appointment data or
                        errors.
        KEYWORDS:

                        ********************


     [5]4110     NAME: Imaging Consults
  CUSTODIAL PACKAGE: CONSULT/REQUEST TRACKING                    Chicago
SUBSCRIBING PACKAGE: IMAGING                                     Washington
                     CLINICAL PROCEDURES
                       CP is only allowed acess to the ASSOCIATED RESULTS
                       (#50) field and all associated sub-fields with read
                       w/FileMan access.
            USAGE: Controlled Subscri  ENTERED: JUL 31,2003
           STATUS: Active              EXPIRES:
         DURATION: Till Otherwise Agr  VERSION:
             FILE: 123                    ROOT: GMR(123,
      DESCRIPTION:                        TYPE: File
```

---

[5] Patch MD*1*2 July 2004 DBIAs added.

```
   Imaging reads fields from the REQUEST/CONSULTATION file to gather
   infomration regarding the consult or procedure being performed to produce
   a patient worklist for modalities. The worklist is displayed on the
   modality for the technician or physician to select the patient and attach
   images to the consult\procedure.
GLOBAL REFERENCE:
  ^GMR(123,
    .02      PATIENT NAME          0;2      Read w/Fileman
     Patient name, pointer to the Patient file (#2).
    1        TO SERVICE            0;5      Read w/Fileman
     The service responsible for completion of the consult/request.
    3        DATE OF REQUEST       0;7      Read w/Fileman
     The date of the request for the consult.
    5        URGENCY               0;9      Read w/Fileman
     The urgency for the consult or request.
    8        CPRS STATUS           0;12     Read w/Fileman
     The current CPRS status of the consult or request.
GLOBAL REFERENCE:
  ^GMR(123,D0,50,
    .01      ASSOCIATED RESULTS    0;1      Read w/Fileman
     The result to be associated with a consult.
   This global allows one or more results to be associated with a consult.
GLOBAL REFERENCE:
  ^GMR(123,D0,40,
    .01      DATE/TIME OF ACTION   0;1      Read w/Fileman
     Acutal date & time the activity tracking update was added to the
     consult or request.
    6        FORWARDED FROM        0;6      Read w/Fileman
     The hospital service that is forwarding the consult.
   Global node has the history of the processing actions for the consult.
       KEYWORDS:


                         **************************


    4231     NAME: DBIA4231
 CUSTODIAL PACKAGE: HEALTH SUMMARY                          Salt Lake City
SUBSCRIBING PACKAGE: CLINICAL PROCEDURES                    Chicago
            USAGE:                        ENTERED: MAY  7,2004
           STATUS: Active                 EXPIRES:
         DURATION: Till Otherwise Agr  VERSION:
      DESCRIPTION:                        TYPE: Routine
  This IA is used to document the CKP^GMTSUP entry point usage.


  CKP^GMTSUP Checks for the end of page and issues a page break if the
  number of lines printed is equal to or greater than the page length minus
  the offset (IOSL-GMTSLO).
```

There are no input parameters, however, this entry point expects to see
the following pre-existing variables in the environment:

```
IOST        Terminal Type
IOF         Form Feed
IOSL        Page Length
GMTSLO      Lines Off-Set (number of lines before IOSL where you break the
            page)
GMTSLPG     Last Page Indicator Flag (set to 0 except on last page)
GMTSDTM     Date and Time (external)
GMTSEG(     Segment Array
GMTSEGN     Segment Number - GMTSEG(GMTSEGN)
GMTSLCMP    Last Component Number
GMTSTITL    Component Title
GMTSPHDR(   Header Array w/Patient Demographics
```

Note: The GMTSPHDR can be set by setting DFN and calling DEM^GMTSU.

```
   ROUTINE: GMTSUP
 COMPONENT:  CKP~GMTSUP
        KEYWORDS:
```

****

```
    4327    NAME: DBIA4327
 CUSTODIAL PACKAGE: ORDER ENTRY/RESULTS REPORTING          Salt Lake City
SUBSCRIBING PACKAGE: CLINICAL PROCEDURES                   Chicago
           USAGE: Private            ENTERED: FEB  3,2004
          STATUS: Active             EXPIRES:
        DURATION: Till Otherwise Agr  VERSION:
            FILE: 101.24                ROOT: ORD(101.24
     DESCRIPTION:                      TYPE: File
```
This is a one time only integration agreement for the conversion of
Medicine components to Medicine/Clinical Procedures components. This
integration agreement is used to document that patch 2 of Clinical
Procedures, MD*1*2, can use FileMan to lookup the entry ORRPW MEDICINE in
the OE/RR Report file (#101.24) and use FileMan to modify ORRPW MEDICINE
to ORRPW MEDICINE/CP and add "Medicine/CP" to the Heading and Descriptive
Text fields.
```
GLOBAL REFERENCE:
  ^ORD(101.24,DA,0)
    .01      NAME               0;1      Both R/W w/Fileman
GLOBAL REFERENCE:
  ^ORD(101.24,DA,2)
    .23      HEADING            2;3      Write w/Fileman
    .24      DESCRIPTIVE TEXT   2;4      Write w/Fileman
        KEYWORDS:
```

****

```
     4328      NAME: DBIA4328
  CUSTODIAL PACKAGE: HEALTH SUMMARY                                 Salt Lake City
SUBSCRIBING PACKAGE: CLINICAL PROCEDURES                           Chicago
              USAGE: Private             ENTERED: JAN 30,2004
             STATUS: Active              EXPIRES:
           DURATION: Till Otherwise Agr  VERSION:
               FILE: 142.1                  ROOT: GMT(142.1
        DESCRIPTION:                        TYPE: File
  This is a one time only integration agreement for the conversion of
  Medicine Components to Medicine/Clinical Procedures Components.  This
  integration agreement is to document that patch 2 of Clinical Procedures,
  MD*1*2, can lookup with FileMan the following entries in the Health
  Summary Components file (#142.1):
        1   MEDICINE ABNORMAL BRIEF
        2   MEDICINE BRIEF REPORT
        3   MEDICINE FULL CAPTIONED
        4   MEDICINE FULL REPORT
        5   MEDICINE SUMMARY
  Clinical Procedures can write to the entries to change the print routine,
  prefix, and description to reflect both Medicine and CP.
  GLOBAL REFERENCE:
    ^GMT(142.1,DA,0)
      .01      NAME                 0;1       Both R/W w/Fileman
      1        PRINT ROUTINE        0;2       Write w/Fileman
      13       PREFIX               0;13      Write w/Fileman
  GLOBAL REFERENCE:
    ^GMT(142.1,DA,.1,0)
      1.1      EXTERNAL/EXTRACT ROU .1;0      Write w/Fileman
  GLOBAL REFERENCE:
    ^GMT(142.1,DA,3.5,0)
      3.5      DESCRIPTION          3.5;0     Write w/Fileman
          KEYWORDS:

                         **************************


     4428      NAME: ORWRP TIME/OCC LIMITS ALL
  CUSTODIAL PACKAGE: ORDER ENTRY/RESULTS REPORTING
     Salt Lake City
SUBSCRIBING PACKAGE: CLINICAL PROCEDURES                           Chicago
              USAGE: Private             ENTERED: MAY 19,2004
             STATUS: Active              EXPIRES:
           DURATION: Till Otherwise Agr  VERSION:
               FILE:                        ROOT:
        DESCRIPTION:                        TYPE: Other
  This DBIA document the usage of the CPRS parameter ORWRP TIME/OCC LIMITS
  ALL. CP uses the $$GET^XPAR("USR.`"_DUZ_"^DIV^SYS^PKG","ORWRP TIME/OCC
  LIMITS ALL",1,"I") call to get the default date/time and occurence limit
  for all reports.  CP will use this call to get the occurence limit so CP
  can return the accurate number of CP data to CPRS for display in the CPRS
  Reports tab.
          KEYWORDS:

                         *********************
```

DBIA's where the Clinical Procedures package is the custodian:

```
     3139      NAME: DBIA3139
  CUSTODIAL PACKAGE: CLINICAL PROCEDURES                        Chicago
SUBSCRIBING PACKAGE: CONSULT/REQUEST TRACKING                   Salt Lake City
                        Field .04 CLINICAL PROCEDURES of GMRC Procedure file
                        #123.3 can point to CP Definition file 702.01.  It
                        uses the screen S DIC("S")="I
                        $F(""OP"",$P(^MDS(702.01,+Y,0),U,2))>1&($P(^(0),U,9))"
                        to list all active procedures and orderable items.

                        File 123 also has a field pointing to file 702.01.
             USAGE: Controlled Subscri  ENTERED: JUN 28,2000
            STATUS: Active                EXPIRES:
          DURATION: Till Otherwise Agr   VERSION:
              FILE: 702.01                   ROOT: MDS(702.01,
       DESCRIPTION:                          TYPE: File
    ^MDS(702.01,
      .01     NAME                0;1      Pointed to
                                           Name of the procedure.


      ROUTINE:


                        * * * * * * * * * * * * * * * * * * * *


     3378      NAME: DBIA3378
  CUSTODIAL PACKAGE: CLINICAL PROCEDURES                        Chicago
SUBSCRIBING PACKAGE: CONSULT/REQUEST TRACKING                   Salt Lake City
                        Consult will be calling the EXTDATA(MDPROC) entry
                        point to determine whether the procedure requires
                        external data.
                        TEXT INTEGRATION UTILITIES              Salt Lake City
                        TIU will be calling the TIUCOMP(MDNOTE) entry point
                        to complete the CP transaction and the TIUDEL(MDNOTE)
                        entry points to update Clinical Procedures that a TIU
                        document is deleted.
                        IMAGING                                 Washington
                        Imaging will be calling the ISTAT(MDARR) entry point
                        to update Clinical Procedures with the result of the
                        image(s) being copied to the Imaging Server.
             USAGE: Controlled Subscri  ENTERED: MAY 14,2001
            STATUS: Active                EXPIRES:
          DURATION: Till Otherwise Agr   VERSION:
              FILE:                          ROOT:
       DESCRIPTION:                          TYPE: Routine
  This IA documents calls to MDAPI.


    ROUTINE: MDAPI
  COMPONENT:  EXTDATA(MDPROC)
  VARIABLES:  MDPROC       Input
                                    The CP Definition IEN from CP DEFINITION
                                    file (702.01)
              OUTPUT       Output
                                    Extrinsic Function returns: 0/1 for
                                    external data needed.
                   Entry Point to check if a medical device is associated with
                   the CP Definition.
```

```
    COMPONENT:  TIUCOMP(MDNOTE)
    VARIABLES:  MDNOTE        Input
                                    The TIU Document IEN from TIU DOCUMENT
                                    file (#8925).
                OUTPUT        Output
                                    Extrinsic Function returns: 0/1 for
                                    fail/success of transaction completion.
                    Entry Point to complete a CP transaction.
    COMPONENT:  TIUDEL(MDNOTE)
    VARIABLES:  MDNOTE        Input
                                    The TIU Document IEN from TIU DOCUMENT
                                    file (#8925).
                OUTPUT        Output
                                    Entrinsic Function returns: 0/1 for
                                    fail/success of the TIU Note deletion
                                    update.
                    Entry Point to clean up the CP Transaction file entry of
                    the TIU Note that was deleted.
    COMPONENT:  ISTAT(MDARR)
    VARIABLES:  MDARR         Input
                                    An array of the following:
                                    MDARR(0)="0^error message" or "1^success
                                    message"
                                    MDARR(1)=TrackID  (CP;Transaction IEN)

                                    MDARR(2)=Image(s) Queue Number

                                    MDARR(3..N)=Warnings, if error(s) exist.
                    Entry Point to update Clinical Procedures of the result of
                    the image(s) that was copied to the Imaging Server.
    COMPONENT:  ITIU(RESULTS,DFN,CONSULT,VSTRING)
    VARIABLES:  RESULTS       Output
                                    RESULTS(0) will equal one of the
                                    following (Required)
                                            ;    IEN of the TIU note if
                                    successful
                                            ;    or on failure one of the
                                    following status messages
                                            ;   -1^No patient DFN
                                            ;   -1^No Consult IEN
                                            ;   -1^No VString
                                            ;   -1^Error in CP transaction
                                            ;   -1^Unable to create CP
                                    transaction
                                            ;   -1^Unable to create the TIU
                                    document
                                            ;   -1^No such consult for this
                                    patient.
                DFN           Input
                                    Patient IEN. (Required)
                CONSULT       Input
                                    Consult IEN. (Required)
                VSTRING       Input
                                    VString data for TIU Note. (Required)
                    This entry point enables VistA Imaging to retrieve/create a
                    TIU note for a consult for attaching images to.
```

****

```
     3613     NAME: Imaging - Visit Info
  CUSTODIAL PACKAGE: CLINICAL PROCEDURES                          Chicago
SUBSCRIBING PACKAGE: IMAGING                                      Washington
                     Imaging is calling GETVST^MDRPCOP to obtain a
                     patient's list of visits.
             USAGE: Private              ENTERED: JUL  3,2002
            STATUS: Active               EXPIRES:
          DURATION: Till Otherwise Agr   VERSION:
              FILE:                          ROOT:
       DESCRIPTION:                         TYPE: Routine
  Imaging has permission, for a limited time, to call GETVST^MDRPCOP and
  obtain a list of patient visit information.  The time frame to be
  identified by Clinical Procedures when the code in GETVST^MDRPCOP is
  changed to call the approved API (SELECTED^VSIT).  Clinical Procedures
  will coordinate with Imaging on the release of the patch and identify the
  passing parameters used in the call to SELECTED^VSIT to ensure continuity
  with both applications (Imaging and Clinical Procedures).


    ROUTINE: MDRPCOP
  COMPONENT:  GETVST
  VARIABLES:  DFN          Input
                                  Patient's dfn.
              RESULTS      Output

                                  A subscripted array that contains a list
                                  of visits:
                                   1st piece has 3 pieces delimited by an
                                  ";"
                                          - type of visit  ("A","I","V")
                                          - date and time
                                          - hospital location ien
                                   2nd piece  - date/time of visit
                                  (internal format)
                                   3rd & 4 piece - (external format)
                                  hospital location and status.
                 This sub-module returns a list of visits for a given
                 patient.

                        *******************

     ⁶3854     NAME: DBIA3854
  CUSTODIAL PACKAGE: CLINICAL PROCEDURES                          Chicago
SUBSCRIBING PACKAGE: CLINICAL CASE REGISTRIES
             USAGE: Private              ENTERED: NOV 26,2002
            STATUS: Active               EXPIRES:
          DURATION: Till Otherwise Agr   VERSION:
       DESCRIPTION:                         TYPE: Routine
  This IA documents the API interface between Clinical Procedures and
  Clinical Case Registries version 1.0.  Prior to calling the API
  GET^MDAPI1(RESULTS,MDARDFN,MDSDT,MDEDT,MDFLDS), the subscriber should
  check the existence of patch MD*1*1.
```

---

[6] Patch MD*1*2 July 2004 DBIA added.

```
   ROUTINE: MDAPI1
 COMPONENT:  GET(RESULTS,MDARDFN,MDSDT,MDEDT,MDFLDS)
             This API returns a list of data from the Electrocardiogram
             file (#691.5) for a patient for a specified start and end
             date.  Only the Electrocardiogram records in the following
             statuses will be returned in the list:

             RELEASED ON-LINE VERIFIED
             RELEASED OFF-LINE VERIFIED
             RELEASED NOT VERIFIED
             RELEASED ON-LINE VERIFIED OF SUPERSEDED
             RELEASED OFF-LINE VERIFIED OF SUPERSEDED
 VARIABLES:  Both       RESULTS
                          Input: The global ^TMP array in which to return
                          results. (Required)

                          Output: Passed by Reference
                                  Global array returned in the FM DIQ call
                                  format:
 VARIABLES:  Input      MDARDFN
                          The patient DFN  (Required).
 VARIABLES:  Input      MDSDT
                          The start date of the date range to return the
                          data in.  This must be in FM internal format.
                          (Required).
 VARIABLES:  Input      MDEDT
                          The end date of the date range to return the data
                          in.  This must be in FM internal format.
                          (Required).
 VARIABLES:  Input      MDFLDS
                          A list of fields from file #691.5 to be returned
                          in RESULTS.  MDFLDS should contain a list of
                          fields delimited by ";"  (Required).
                              example: MDFLDS=".01;11;20..."

                          Example API call:

                          S RESULTS="^TMP(""NAMESPACE"",$J)"
                          D GET^MDAPI1(.RESULTS,162,2900101,3021001,
                                       ".01;11")

                          return:

                            ^TMP("NAMESPACE",$J,file #,record ien_","
                                ,field #,"E")=Data
                            ^TMP("NAMESPACE",$J,subfile #,entry #_","_
                                record ien field of the multiple,"E")=data


                                  ^TMP("NAMESPACE",$J,0) will equal one of
                                  the following,
                                    If the call failed:
                                       -1^No Patient DFN.
                                       -1^No Start Date Range
                                       -1^No End Date Range.
                                       -1^Start Date greater than End Date.
                                       -1^No fields defined.
```

```
                                    If a local variable is defined in
                                    RESULTS,
                                      ^TMP("MDAPI",$J,0) equals
                                      -1^Global TMP array only.


                                    If no return array defined,
                          ^TMP("MDAPI",$J,0) equals
                                      -1^No return array global.


                                    If no data, ^TMP("NAMESPACE",$J,0)
                                    equals -1^No data for patient.
          KEYWORDS:

                          *******************
```

[7]4230   NAME: DBIA4230
 CUSTODIAL PACKAGE: CLINICAL PROCEDURES   Chicago
SUBSCRIBING PACKAGE: HEALTH SUMMARY   Salt Lake City
                    ORDER ENTRY/RESULTS REPORTING   Salt Lake City
              USAGE: Controlled Subscri   ENTERED: AUG 29,2003
             STATUS: EXPIRES:
           DURATION: Till Otherwise Agr   VERSION:
        DESCRIPTION: TYPE: Routine
   This DBIA documents the usage of the MDPS1 entry points for displaying the
   Clinical Procedures result reports.

      ROUTINE: MDPS1
    COMPONENT: CPA~MDPS1
                This entry point will display Clinical Procedures result
                report that have the Procedure Summary Code of ABNORMAL. The
                result consists of the detailed report of the Consult
                procedure request, if it exists, and the TIU document text.

                The following variables are inputs from the local symbol
                table:
                    DFN
                    GMTS1
                    GMTS2
                    GMTSNDM
                    GMTSNPG
                    GMTSQIT
    VARIABLES: Input   DFN
                             Patient Internal Entry Number. (Required)
    VARIABLES: Input   GMTS1
                             The ending date in inverse date format
                             (9999999-date/time). (Required)
    VARIABLES: Input   GMTS2
                             The beginning date in inverse date format
                             (9999999-date/time). (Required)
    VARIABLES: Input   GMTSNDM
                             The maximum number of entries to return.
                             (Optional)

---

[7] Patch MD*1*2 July 2004 DBIA added.

```
  VARIABLES:  Input      GMTSNPG
                            The Page Number. (Optional)
  VARIABLES:  Input      GMTSQIT
                            Quit indicator. (Optional)
  COMPONENT:  CPB~MDPS1
              This entry point will display a brief summary of the Clinical
              Procedures result Report.  It displays the Consults # (if it
              exists), Procedure Name, Date/Time Performed, and the
              Procedure Summary Code.

              The following variables are inputs from the local symbol
              table:
                 DFN
                 GMTS1
                 GMTS2
                 GMTSNDM
                 GMTSNPG
                 GMTSQIT
  VARIABLES:  Input      DFN
                            Patient Internal Entry Number. (Required)
  VARIABLES:  Input      GMTS1
                            The ending date in inverse date format
                            (9999999-date/time).  (Required)
  VARIABLES:  Input      GMTS2
                            The beginning date in inverse date format
                            (9999999-date/time).  (Required)
  VARIABLES:  Input      GMTSNDM
                            The maximum number of entries to return.
                            (Optional)
  VARIABLES:  Input      GMTSNPG
                            The Page Number. (Optional)
  VARIABLES:  Input      GMTSQIT
                            Quit indicator. (Optional)
  COMPONENT:  CPF~MDPS1
              This entry point displays the full Clinical Procedures result
              report.  The full report consists of the detailed report of
              the Consult procedure request, if it exists, and the TIU
              document text.

              The following variables are inputs from the local symbol
              table:

                 DFN
                 GMTS1
                 GMTS2
                 GMTSNDM
                 GMTSNPG
                 GMTSQIT
  VARIABLES:  Input      DFN
                            Patient Internal Entry Number. (Required)
  VARIABLES:  Input      GMTS1
                            The ending date in inverse date format
                            (9999999-date/time).  (Required)
  VARIABLES:  Input      GMTS2
                            The beginning date in inverse date format
                            (9999999-date/time).  (Required)
```

```
VARIABLES:  Input      GMTSNDM
                          The maximum number of entries to return.
                          (Optional)
VARIABLES:  Input      GMTSNPG
                          The Page Number. (Optional)
VARIABLES:  Input      GMTSQIT
                          Quit indicator. (Optional)
COMPONENT:  CPS~MDPS1
            This entry point displays a one line summary of the Clinical
            Procedures result report.  The one line summary consists of
            the Consult Number, if it exists, Procedure Name, Date/Time
            Performed, and the Procedure Summary Code.

            The following variables are inputs from the local symbol
            table:

               DFN
               GMTS1
               GMTS2
               GMTSNDM
               GMTSNPG
               GMTSQIT
VARIABLES:  Input      DFN
                          Patient Internal Entry Number. (Required)
VARIABLES:  Input      GMTS1
                          The ending date in inverse date format
                          (9999999-date/time).  (Required)
VARIABLES:  Input      GMTS2
                          The beginning date in inverse date format
                          (9999999-date/time).  (Required)
VARIABLES:  Input      GMTSNDM
                          The maximum number of entries to return.
                          (Optional)
VARIABLES:  Input      GMTSNPG
                          The Page Number. (Optional)
VARIABLES:  Input      GMTSQIT
                          Quit indicator. (Optional)
COMPONENT:  EN1~MDPS1(MDGLO,MDDFN,MDSDT,MDEDT,MDMAX,MDPSC,MDALL)
            This entry point returns a global Array.

            Returns:

            ^TMP("MDHSP",557918815,1) = ECG^1200^EN2^MDPS1^^JUL
                                          24,2002@13:39^NORMAL^^^^^1200^1642
            ^TMP("MDHSP",557918815,2) = SPIROMETRY, PRE
            &POST^1047^EN2^MDPS1^^
                                          JUL 3,2002@13:45^^^^^^1047^1570
            ^TMP("MDHSP",557918815,3) = ECHO^820^EN2^MDPS1^^MAR
            4,2002@12:21^
                                          ABNORMAL^^^^^820^1399


            Piece 1: Procedure Name Piece 2: study internal entry number
            (MCARGDA) Piece 3 & 4: Label and entry point routine Piece 6:
            Date/Time Performed Piece 7: Procedure Summary Code Piece 12:
            same as piece 2 Piece 13: Consult number
```

```
            If MDALL=1, the ^TMP("MDPTXT",$J) global will return the text
            of the procedure reports. The study internal entry number
            (MCARGDA) will identify the location where the text is within
            the ^TMP("MDPTXT",$J) global.

            Global ^TMP("MDPTXT",$J
                    TMP("MDPTXT",$J ^TMP("MDPTXT",557939153,820,"Procedure
            name",1,0) = Current Pat. Status:   Inpatient
            ^TMP("MDPTXT",557939153,820,"Procedure name",2,0) = Ward:
                     3AS ^TMP("MDPTXT",557939153,820,"Procedure
            name",3,0) = ^TMP("MDPTXT",557939153,820,"Procedure name",4,0)
            = Order Information ^TMP("MDPTXT",557939153,820,"Procedure
            name",5,0) = To Service:           CARDIOLOGY
```

VARIABLES: Both   MDGLO
                      Return Global Array (Required)
VARIABLES: Input   MDDFN
                      Patient DFN (Internal Entry Number)
                      (Required)
VARIABLES: Input   MDSDT
                      Start Date in FM Internal Format (Optional)
VARIABLES: Input   MDEDT
                      End Date in FM Internal Format (Optional)
VARIABLES: Input   MDMAX
                      Number of studies to return   (Optional)
VARIABLES: Input   MDPSC
                      Procedure Summary Code to return. The four
                      Procedure Summary Code are NORMAL, ABNORMAL,
                      BRODERLINE, and INCOMPLETE. By passing this
                      parameter, the entry point will pass studies with
                      this Procedure Summary Code. (Optional)
VARIABLES: Input   MDALL
                      MDALL is flag. If MDALL =1, it identifies that
                      all text reports with the procedures list should
                      be returned.
COMPONENT: EN2~MDPS1
            This entry point will displays the text of the Clinical
            Procedures result report. This entry point have to be used
            along with EN1^MDPS1. EN1^MDPS1 will return the TMP global of
            the list of studies. Piece 2 is the study internal entry
            number. Set MCARGDA to equal the study internal intry number
            before calling EN2^MDPS1. EN2^MDPS1 is called to display each
            study.
VARIABLES: Input   MCARGDA
VARIABLES: Input   ORHFS
                         If ORHFS exists, EN2 will use IO to print the text
                         report.
COMPONENT: PR690~MDPS1
            Prints the free text of the Medicine report.

            The following variables are inputs from the local symbol
            table:
               DFN
               MCARGDA
               MCPRO
               ORHFS

```

```
VARIABLES: Input   MCARGDA
                           The internal entry number of the Medicine report
                           record.
VARIABLES: Input   MCPRO
                           The free text of the Medicine procedure name in
                           the Procedure/Subspecialty file (#697.2).
VARIABLES: Input   DFN
                           Patient internal entry number.
VARIABLES: Input   ORHFS
                           Order Entry Host File.
COMPONENT: PR702~MDPS1
             Prints the free text of the Clinical Procedures result
             interpretation.

             The following variables are inputs from the local symbol
             table:
                 DFN
                 MCARGDA
                 MCPRO
                 ORHFS
VARIABLES: Input   MCARGDA
                           The internal entry number of the CP Transaction
                           record in file (#702).
VARIABLES: Input   MCPRO
                           The free text of the CP Definition name in file
                           (#702.01).
VARIABLES: Input   DFN
                           Patient internal entry number.
VARIABLES: Input   ORHFS
                           The Order Entry Host File.
         KEYWORDS:

                          ****
```